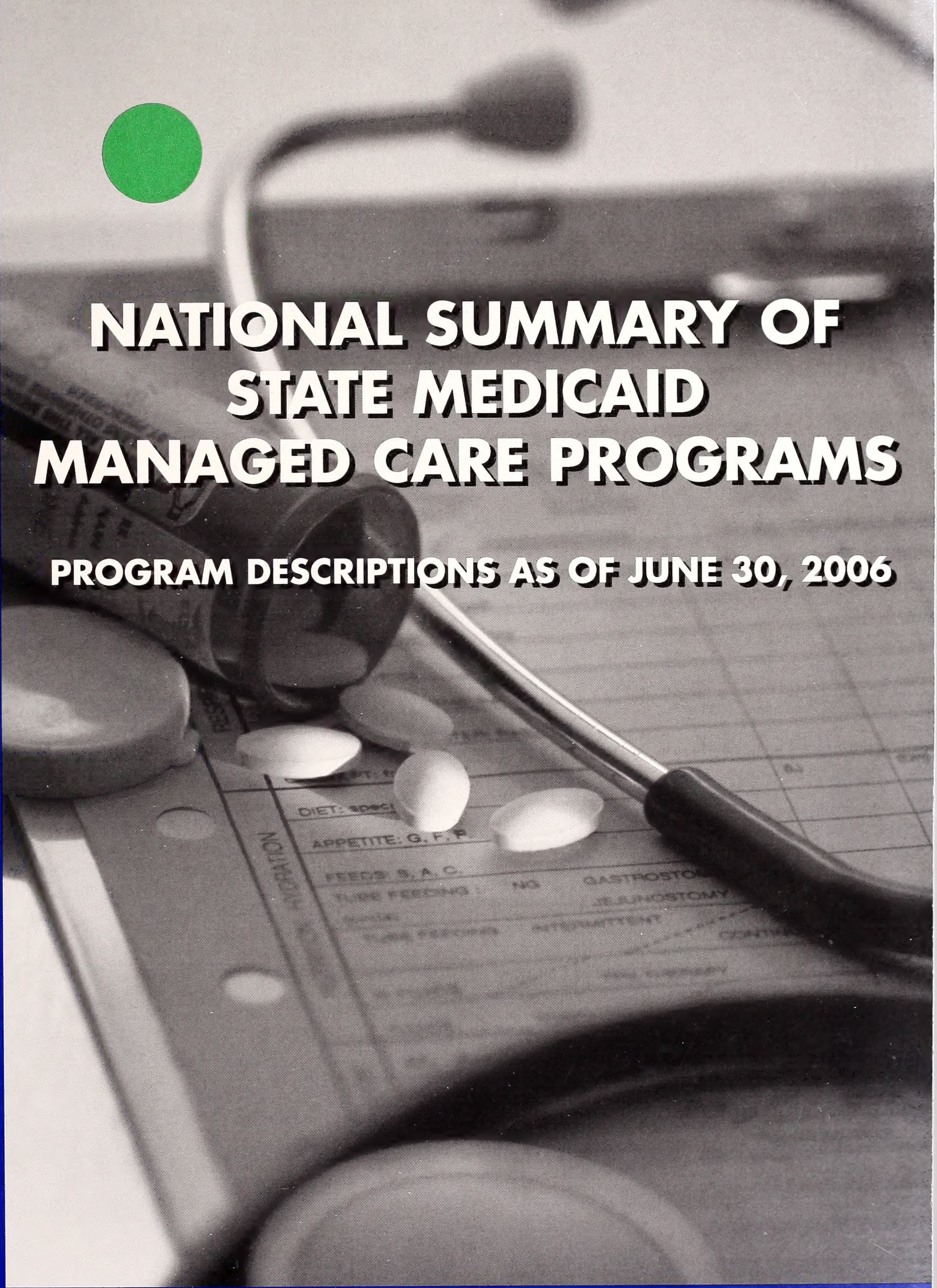

NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS

PROGRAM DESCRIPTIONS AS OF JUNE 30, 2006

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Centers for Medicare & Medicaid Services

2006 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS

PROGRAM DESCRIPTIONS AS OF JUNE 30, 2006

The National Summary of State Medicaid Managed Care Programs is composed annually by the Finance, Systems, and Budget Group (FSBG) of the Centers for Medicare & Medicaid Services (CMS). The report provides descriptions of the States' Medicaid managed care programs as of June 30, 2006. **An (*) asterisk next to the State's Medicaid program name indicates the Program is a "Non-Managed Care Waiver."** The data was collected from State Medicaid Agencies and CMS Regional offices, and submitted for review to FSBG, Family and Children's Health Program Group (FCHPG), and Disabled and Elderly Health Program Group (DEHPG).

Please contact Carolyn Lawson at 410-786-0704; e-mail carolyn.lawson@cms.hhs.gov or Loan Swisher at 410-786-4650; e-mail: loan.swisher@cms.hhs.gov, or Joseph DelPilar at 410.786-0081; e-mail: joseph.delpilar@cms.hhs.gov of the FSBG staff, if you have any questions concerning this report.

NOTE: National Summary tables are included at the end of the report.

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ALABAMA
Maternity Care Program

CONTACT INFORMATION

State Medicaid Contact:

Gloria Luster
Alabama Medicaid Agency
(334) 353-5539

State Website Address:

http://www.medicaid.alabama.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 01, 2004

Implementation Date:
September 23, 2005

Waiver Expiration Date:
November 30, 2006

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Home Visits, Inpatient Hospital, Outpatient Hospital, Physician

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

ALABAMA
Maternity Care Program

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance, if HMO
-Illegal aliens
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Poverty-Level Pregnant Women
-SSI over 19 eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations
-Refugees
-American Indian/Alaskan Native

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

ADDITIONAL INFORMATION

The reimbursement methodology for the maternity program is capitated "at risk" to a health entity assigned in each district throughout the State. State contracts with a primary contractor that enters into a contractual agreement with each maternity subcontractors serving the district. The providers are paid a fee once the woman delivers. The primary contractor is responsible for submitting a claim for payment. Upon receipt of payment from Medicaid, the primary contractor pays all subcontractors involved in the woman's care. Program was converted from a 1932(a) to a 1915(b) on 9/23/05 as the Patient 1st waiver was amended to include Maternity Care. Maternity Care primary contractors are reimbursed by a contracted global fee. The state is in the beginning process of obtaining an EQRO.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Access to subcontractors who are 50 miles/50 minutes of recipient

Health Plan Stability/ Financial/Cost of Care:
None

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization:
-Percentage of women who began prenatal care during first 13 weeks of pregnancy
-Percentage of women who enroll when already pregnant, who begin prenatal care within 6 weeks after enrolling
-Percentage of women with live births who had post-partum visit between 21-56 days after delivery
-Percentage who have recommended number of pre-natal visits per ACOG

Health Plan/ Provider Characteristics:
None

Performance Improvement Projects

Project Requirements:
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:
-Appeals, grievances and other complaints
-Availability, accessibility & cultural competency of services
-Interpersonal aspects of care

Clinical Topics:
-Low birth-weight baby
-Pre-natal care
-Smoking prevention and cessation

Standards/Accreditation

ALABAMA
Maternity Care Program

PIHP Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-QIO-like entity

Accreditation Required for Participation:
None

EQRO Name:
-Software Engineering Services (SES)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities

ALABAMA
Patient 1st

CONTACT INFORMATION

State Medicaid Contact:

Paige Clark
Alabama Medicaid Agency
(334) 242-5148

State Website Address:

www.medicaid.alabama.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
October 01, 2004

Implementation Date:
December 01, 2004

Waiver Expiration Date:
November 30, 2006

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Infants of SSI Mothers
- -Refugees
- -American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:

- -Medicare Dual Eligibles
- -Poverty Level Pregnant Woman
- -Other Insurance
- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Recipient is a lock-in
- -Recipient is determined to be medically exempt
- -Children under 19 who are eligible for SSI
- -Foster Care Children

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Self Referrals
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Aging Agency
- -Developmental Disabilities Agency
- -Mental Health Agency
- -Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Patient 1st

ADDITIONAL INFORMATION

Program was restructured on October 1, 2004. The 12 months guaranteed eligibility applies to children born to Medicaid eligible mothers and if child remains in mother's home.

ALABAMA
Patient 1st

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
- -Consumer Self-Report Data
- -Independent assessment of program impact, access, quality & cost-effectiveness
- -Performance Measures (see below for details)
- -Provider Data

Consumer Self-Report Data:
- -State-developed Survey

Use of Collected Data:
- -Contract Standard Compliance
- -Fraud and Abuse
- -Monitor Quality Improvement
- -Program Evaluation
- -Provider Profiling
- -Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality:
- -Immunizations for two year olds
- -Lead screening rate
- -Well-child care visit rates in 3, 4, 5, and 6 years of life
- -Well-child care visit rates in first 15 months of life

Access/Availability of Care:
- -Average distance to primary care case manager
- -Average wait time for an appointment with primary care case manager

Provider Characteristics:
None

Health Status/Outcomes Quality:
- -Asthma emergency room visits
- -Diabetic patients with A1C tests
- -Patient satisfaction with care
- -Percentage of patients with PMP vs. referral rate

Use of Services/Utilization:
- -Drug Utilization
- -Emergency room visits/1,000 beneficiaries

Beneficiary Characteristics:
None

ALASKA
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Michelle Lyons-Brown
Department of Health and Social Services
(907) 465-3030

State Website Address:

www.alaska.fhsc.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 18, 2005

Implementation Date:
March 01, 2006

Waiver Expiration Date:
December 31, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

FFS Transportation Broker - Fee-for-Service

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-American Indian/Alaskan Native

-Poverty-Level Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Employment Agencies
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

None

ARKANSAS
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Roy Jeffus
Medicaid Agency
(501)682-8740

State Website Address:

http://medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
December 04, 1997

Implementation Date:
March 01, 1998

Waiver Expiration Date:
September 30, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Special Needs Children (State defined)

ARKANSAS
Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:

- Reside in Nursing Facility or ICF/MR
- Medicare Dual Eligibles
- Special Low Income Beneficiaries
- ARKids First-B
- Women Health (FP)
- Eligibility only Retroactive
- Tuberculosis

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

Children with special needs due to physical and/or mental illnesses and foster care children who are categorically eligible.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Field Audits
- Monitoring of PAHP Standards
- On-Site Reviews

Use of Collected Data:

- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal

-PAHP Standards
-Provider Data

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

ARKANSAS
Primary Care Physician

CONTACT INFORMATION

State Medicaid Contact:

Roy Jeffus
State Medicaid Agency
(501) 682-1671

State Website Address:

http://www.medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 11, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
March 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Physician, Podiatry, X-Ray

Allowable PCPs:
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Family Practitioners
-Pediatricians
-Area Health Education Centers (AHECs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-1115 Demonstration Waiver (AR Kids B)

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligibles
-Eligiblity Period that is Retroactive
-Medically Needy "Spenddown" Categories

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care

ADDITIONAL INFORMATION

All included services requires PCP referral. All other services available in Medicaid FFS do not require referral. EPSDT is only available in 25 counties.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data

Use of Collected Data:
-Beneficiary Provider Selection

- -Enrollee Hotlines
- -Performance Measures (see below for details)
- -Provider Data

- -Health Services Research
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Provider Profiling
- -Track Health Service provision

Consumer Self-Report Data:
-Satisfaction Survey

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Ratio of primary care case managers to beneficiaries

Provider Characteristics:
None

Health Status/Outcomes Quality:
-Number of children with diagnosis of rubella(measles)/1,000 children
-Percentage of low birth weight infants

Use of Services/Utilization:
-Inpatient admissions/1,000 beneficiaries

Beneficiary Characteristics:
None

CALIFORNIA

Caloptima

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 19, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Midwives
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-Nurse Practitioners
-Federally Qualified Health Centers (FQHCs)

Enrollment

CALIFORNIA
Caloptima

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-SCHIP Title XXI Children (State only Healthy Families)
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Caloptima-Orange

ADDITIONAL INFORMATION

CalOptima has special waiver authority under OBRA 1990.

CALIFORNIA
Caloptima

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Drug Rebate
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:
Yes

Performance Measures

CALIFORNIA
Caloptima

Process Quality:
- -Adolescent immunization rate
- -Asthma care - medication use
- -Breast Cancer screening rate
- -Cervical cancer screening rate
- -Check-ups after delivery
- -Chlamdyia screening in women
- -Diabetes medication management
- -Immunizations for two year olds
- -Initiation of prenatal care - timeliness of
- -Well-child care visit rates in 3,4,5, and 6 years of life
- -Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- -Patient satisfaction with care

Access/Availability of Care:
- -Average distance to PCP

Use of Services/Utilization:
- -Drug Utilization
- -Emergency room visits/1,000 beneficiary
- -Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
- -Actual reserves held by plan
- -Days in unpaid claims/claims outstanding
- -Medical loss ratio
- -Net income
- -Net worth
- -State minimum reserve requirements
- -Total revenue

Health Plan/ Provider Characteristics:
- -Board Certification

Beneficiary Characteristics:
- -Information on primary languages spoken by beneficiaries
- -MCO/PCP-specific disenrollment rate
- -Percentage of beneficiaries who are auto-assigned to MCO

Performance Improvement Projects

Project Requirements:
- -MCOs are required to conduct a project(s) of their own choosing
- -All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
- -Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:
- -Adolescent Health
- -Initial Health Assessment

Clinical Topics:
- -Adolescent Health statewide collabortive
- -Breast cancer screening (Mammography)
- -Hospital Quality small group collaborative

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

EQRO Name:
-Delmarva Foundation

CALIFORNIA

Caloptima

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

CALIFORNIA

Central Coast Alliance for Health

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird Rico
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1996

Implementation Date:
January 01, 1996

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-OBRA 1985 & 1990

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Developmental, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Pediatricians
-General Practitioners

Enrollment

CALIFORNIA
Central Coast Alliance for Health

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Medicare Bene
- Qualified Disabled and working Individuals
- Quality Improvement
- Specified Low Income Medicare Benes
- SCIP Title XXI Children (State only Healthy Families)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Central Coast Alliance For Health

ADDITIONAL INFORMATION

CALIFORNIA
Central Coast Alliance for Health

Central Coast Alliance for Health has a special waiver authority under OBRA 1990.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Drug rebate
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
- Adult Medicaid AFDC Questionnaire
- Child Medicaid AFDC Questionnaire
- Child with Special Needs Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

Performance Measures

CALIFORNIA
Central Coast Alliance for Health

Process Quality:
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to PCP

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:

-Adolescent Health Statewide Collaborative
-Asthma management
-Chronic Pain
-Diabetes management
-Frequent ED

Non-Clinical Topics:

-Not Applicable

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation

CALIFORNIA
Central Coast Alliance for Health

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

CALIFORNIA
Health Plan of San Mateo

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 30, 1987

Implementation Date:
November 30, 1987

Waiver Expiration Date:
September 30, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

MCO/COHS - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Nurse Midwives
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles
-Foster Care Children
-Breast Cervical Cancer Preventive treatment
-Children with Accelerated Eligibility
-Title XXI SCHIP (non-State only Healthy Families)

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in another Managed Care Program
-SCHIP Title XXI Children (State only Healthy Families)
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligiblity and claims data to identify members of these groups,
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of San Mateo

ADDITIONAL INFORMATION

Health Plan of San Mateo has special waiver authority under COBRA 1985. MCO/COHS is a County Organized Health System.

QUALITY ACTIVITIES FOR MCO/HIO

CALIFORNIA

Health Plan of San Mateo

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate

Health Status/Outcomes Quality:

-Patient satisfaction with care

-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Diabetes medication management
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Average distance to PCP

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan/ Provider Characteristics:
-Board Certification

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:

-Initial Health Assessments

Clinical Topics:

-Adolescent Health statewide collaborative
-Diabetes management small group collaborative

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Delmarva Foundation

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

CALIFORNIA

Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

State Medicaid Contact:

Rita McCabe
Mental Health
(916) 651-9370

State Website Address:

http://www.dmh.cahwnet.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 15, 1995

Implementation Date:
March 15, 1995

Waiver Expiration Date:
April 01, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) Method of Administration

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental health plans - Fee-for-Service

Service Delivery

Included Services:
Inpatient Mental Health, Outpatient Mental Health, Targeted Case Management

Contractor Types:
None

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-State-Only Medi-Cal and Emergency Services only populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Individuals with special health care needs by performance outcome surveys.

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Mental Health

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

Plan not at risk for federal financial participation. All Medicaid eligibles are automatically enrolled. This program covers specialty mental health services. County mental health departments have first right of refusal to serve as the mental health plan.

CALIFORNIA
Partnership Health Plan of California

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 01, 1994

Implementation Date:
May 01, 1994

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Long Term Care - Counseling and Social Support, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children

-Medi-Cal eligibles with a share of cost and Medically Needy
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-SCHIP Title XXI Children (state only Healthy Families
-Medicare Dual Eligibles

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Partnership Health Plan

ADDITIONAL INFORMATION

Partnership Health Plan has special waiver authority under OBRA 1990. In Yolo County, a small Health Plan, Sutter Senior Care, that serves a limited number of zip codes, coexist, in a county with a County Organized Health System. Laboratory, Long Term Care, Counseling and Social Support, Outpatient Hospital, Outpatient Mental Health - Inpatient and outpatient mental health services are only available in Solano county.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Drug Rebate
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

State conducts general data completeness assessments:

Yes

Performance Measures

CALIFORNIA
Partnership Health Plan of California

Process Quality:
- Adolescent well-care visit rate
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Chlamdyia screening in women
- Diabetes medication management
- Initiation of prenatal care - timeliness of
- Well-child care visit rates in 3,4,5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Access/Availability of Care:
- Average distance to PCP

Health Plan Stability/ Financial/Cost of Care:
- Actual reserves held by plan
- Days in unpaid claims/claims outstanding
- Medical loss ratio
- Net income
- Net worth
- State minimum reserve requirements
- Total revenue

Beneficiary Characteristics:
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCO

Health Status/Outcomes Quality:
- Patient satisfaction with care

Use of Services/Utilization:
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary

Health Plan/ Provider Characteristics:
- Board Certification

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing
- All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
- Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:
- Not Applicable

Clinical Topics:
- Adolescent Health statewide collaborative
- Childhood Immunization
- Diabetes management
- Improving Breast Cancer Screening Rates

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
- Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
- Delmarva Foundation

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects

-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

CALIFORNIA

Santa Barbara Health Initiative

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 01, 1983

Implementation Date:
September 01, 1983

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education and Counseling, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Rual Health Clinic (RHC) Services, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives

Enrollment

CALIFORNIA
Santa Barbara Health Initiative

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in another Medicaid Managed Care program
- Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
SSI

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None - managed care entity provides standard prescription drug coverage

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Santa Barbara Regional Health Authority

ADDITIONAL INFORMATION

Operating authority under 1903(m).

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:

-Contract Standard Compliance
-Drug Rebate
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:

Yes

Performance Measures

CALIFORNIA
Santa Barbara Health Initiative

Process Quality:
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes medication management
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to PCP

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:

-Adolescent Health Statewide
-Asthma management

Non-Clinical Topics:

-Decreasing Inappropriate ER Use
-Decreasing Inappropriate Use of Antibiotics

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

CALIFORNIA

Selective Provider Contracting Program

CONTACT INFORMATION

State Medicaid Contact:

Sunni Burns
Medi-Cal Operations
(916) 552-9115

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 21, 1982

Implementation Date:
September 21, 1982

Waiver Expiration Date:
August 31, 2010

Sections of Title XIX Waived:
-1902(a)(13)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(5)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

This waiver allows CA to selectively contract with hospitals to provide acute inpatient care to all Medi-Cal beneficiaries. This waiver does not differentiate by beneficiary aid code.

COLORADO

Colorado Medicaid Community Mental Health Services Program

CONTACT INFORMATION

State Medicaid Contact:

Jerry Smallwood
Department of Health Care and Financing
(303) 866-5947

State Website Address:

http://www.chcpf.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 04, 1993

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Assertive Community Treatment, Clinic Services, Case Management, Clubhouses and Drop-in Centers, Crisis, Home Based Services for Children and Adolescents, IMD, Inpatient Mental Health, Intensive Case Management, Medication Management, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Prevention Programs (MH), Psychiatrist, Psychosocial Rehabilitiation, Recovery Services, Respite Care, School Based Services, Specialized Services for Addressing Adoption Issues, Vocational Services

Contractor Types:
-Behavioral Health MCO (Private)

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

COLORADO
Colorado Medicaid Community Mental Health Services Program

Populations Voluntarily Enrolled:
-Poverty-Level Pregnant Women
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:
-Title XXI SCHIP
-Undocumented Alien
-Program of all-inclusive Care for the Elderly (PACE)
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Care
Colorado Health Partnerships
Northeast Behavioral Health
Behavioral Healthcare, Inc.
Foothills Behavioral Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Monitoring of PIHP Standards
- On-Site Reviews
- Performance Measures (see below for details)
- PIHP Standards

Consumer Self-Report Data:
- Mental Health Statistics Improvement Program (MHSIP)

Use of Collected Data:
- Contract Standard Compliance
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Requirements for data validation
- Requirements for PIHPs to collect and maintain encounter data

Collection: Standardized Forms:
None

PIHP conducts data accuracy check(s) on specified data elements:
- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

Collections: Submission Specifications:
None

Validation - Methods:
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation
- Per member per month analysis and comparisons across PIHPs

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Access/Availability of Care:
- Ratio of mental health providers to number of beneficiaries

Health Status/Outcomes Quality:
- Patient satisfaction with care

Use of Services/Utilization:
- Average number of visits to MH/SUD providers per beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
- Re-admission rates of MH/SUD

COLORADO
Colorado Medicaid Community Mental Health Services Program

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

Standards/Accreditation

PIHP Standards:
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Conduct of performance improvement projects
-Technical assistance to PIHPs to assist them in conducting quality activities

CONNECTICUT
HUSKY A

CONTACT INFORMATION

State Medicaid Contact:	Ellen Tracy Department of Social Services (860) 424-5215
State Website Address:	http://www.huskyhealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
Affiliated Computer Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 20, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Clinics, Dental, Durable Medical Equipment, EPSDT, Family Planning, Federally Qualified Health Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Intermediate Care Facilities, Laboratory, Nurse Practitioners, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Outreach, Pediatrics, Pharmacy, Physical Therapy, Physician, Podiatry, Pre-natal, Rural Health Clinics, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants

Enrollment

CONNECTICUT
HUSKY A

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Children in Katie Beckett Waiver
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Children in Targeted Case Management under Department of Mental Health and Addiction Services
-Children in Targeted Case Management under Department of Mental Retardation

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-Pregnant Women

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Child Welfare Agency
-Education Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Care Family Plan
HealthNet - Healthy Options
Community Health Network of Connecticut
WellCare Health Plan - Preferred One

ADDITIONAL INFORMATION

None

CONNECTICUT
HUSKY A

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-State conducts multiple critical edits to ensure data accuracy

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visits during first 15 months of life

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Ratio of Dental Providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-EPSDT Visit Rates
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percent of beneficiaries using any MH or SUD services

Health Plan Stability/ Financial/Cost of Care:
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:

-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Pre-natal care

Non-Clinical Topics:

None

Standards/Accreditation

CONNECTICUT
HUSKY A

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Mercer

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Monitor performance improvement projects
-On-site operations reviews
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Population Categories Included:
A subset of MCO members, defined by beneficiary age

Clinical Conditions:
Well-child visits

Initial Year of Reward:
2006

Program Payers:
Medicaid is the only payer

Rewards Model:
Incentives for Providers

Measurement of Improved Performance:
Undetermined

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

FLORIDA

Florida Coordinated Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Glen C. Davis
Florida Agency for Health Care Administration
(850) 922-7305

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 07, 2001

Implementation Date:
November 01, 2004

Waiver Expiration Date:
December 31, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Other

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:
None

-Presumptively Eligible Pregnant Women
-American Indian/Alaskan Native
-Medically Needy
-Family Planning Waiver Recipients

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Commission for the Transportation of the Disadvantaged

ADDITIONAL INFORMATION

The 1915(b) authority is used to selectively contract for non-emergency transportation services with the Commission for the Transportation Disadvantaged. The commission subcontracts with a single community transportation coordinator in each county. Paraexcluded Population: Persons enrolled in another managed care program that provides transportation are excluded from enrolling in this program. Special Needs children are those children classified as SSI. Reimbursement is given in a lump sum, twice a month for non-emergency transportation services. This program does not meet the definition of capitation because the fixed rate is not tied to the number of riders, but rather is a fixed rate over a period of time regardless of the number of riders. Foster care children receiving medical care are voluntarily enrolled.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- -Encounter Data (see below for details)
- -Monitoring of PAHP Standards
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
- -Contract Standard Compliance
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data

Collection: Standardized Forms:
None

PAHP conducts data accuracy check(s) on specified data elements:
None

Collections - Submission Specifications:
None

Validation - Methods:
None

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Access/Availability of Care:
None

Health Plan Stability/ Financial/Cost of Care:
None

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
None

Performance Improvement Projects

Project Requirements:
None

Non-Clinical Topics:
Not Applicable - PAHPs are not required to conduct common project(s)

Clinical Topics:
None

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

FLORIDA
Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:	Linda Macdonald Agency for Health Care Administration (AHCA) (850) 487-2355
State Website Address:	http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
ACS - Concera Corp

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1990

Implementation Date:
October 01, 1992

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Hospital Based Network PIHP (risk, noncomprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Midwives
-Psychiatrists

FLORIDA
Managed Health Care

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Hospice
-Share of cost (Medically needy)
-Children in Residential Treatment Facilities
-Eligibles in Residential Group Care
-HIV/AIDS Waiver Enrollees
-Medicaid Eligibles in Residential Committment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Prescribed Pediatric Extended Care Center Residents
-Residents in ADM Residential Treatment Facilities
-State Hospital Services
-Participate in HCBS Waiver
-Retroactive Eligibility
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Disease Management PAHP - Non-risk Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Obstetricans/Gynecologists or Gynecologists
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman
-Share of Cost (Medically needy)
-State Hospital Services
-Hospice
-Medically needy
-Medicaid Eligibles in Residential Committment Facilities
-Eligibles in Residential Group Care
-Children in Residential Treatment Facilities
-Residents in ADM Residential Treatment Facilities
-Participate in HCBS Waiver
-Prescribed Pediatric Extended Care Center Residents
-Medically Complex Children in CMS Program
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-HIV/AIDS Waiver Enrollees

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Community Mental Health Services, Dental, Durable Medical Equipment, EPSDT, Family Planning, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Targeted Case Management, Occupational Therapy, Outpatient Hospital, Physical Therapy, Respiratory Therapy, Speech Therapy, X-Ray

Allowable PCPs:
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Other Insurance
-Hospice
-Share of Cost (medically needy)
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Medicaid Recipients Age 21 Years and Older
-Reside in Nursing Facility or ICF/MR
-Enrolled in an HMO that provides full dental coverage in Miami-Dade county
-Special Needs Children (State defined)
-Retroactive Eligibility

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

FLORIDA
Managed Health Care

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Health, Inc.
Amerigroup Florida, Inc.
Buena Vista
Florida: A Healthy State
Healthy Palm Beaches
LifeMasters
Preferred Medical Plan, Inc.
StayWell
Total Health Choice
United Healthcare dba Evercare
Vista South Florida
AIDS Healthcare Foundation
Atlantic Dental, Inc.
Citrus Health Care
HealthEase
Humana Family
MediPass
Provider Service Network
The Public Health Trust of Dade County / JMH
United Healthcare
Universal Healthcare

ADDITIONAL INFORMATION

The Disease Management PAHP is specifically for persons with one or more of the following diseases: HIV/AIDS, Congestive Heart Failure, Diabetes, Asthma, and Hypertension. The Disease Management program reimbursement arrangement is not capitated or ffs but is based on shared savings.

PCCM enrollees in 15 counties receive mental health services through a capitated arrangement. Enrollees are allowed to choose either the fee-for-service or a capitated health plan. If the enrollee fails to make a choice, they are mandatory enrolled into a capitated health plan.

Dental and Transportation services are provided at the option of the Plan and the Agency.

Included Populations: Blind/Disabled Adults and Related Populations and Medicare Dual Eligibles are enrolled mandatorily for ages 18-20. Excluded Populations: Persons under 21 residing in a Nursing Facility or ICF/MR. Community Mental Health Services are Provided in Area 6 only. Reimbursement is varied throughout program. Some vendors are paid on a per member per month basis, others are paid on a nurse FTE basis, and some are paid based on contract deliverables.

The Provider Service Network (PSN) shared savings model receives an administrative advance and a case management fee for all enrolled beneficiaries. The claims for the enrollees are paid fee-for-service. Th shared savings model PSN is at risk potentially for 50% of any administrative advance. The agency conducts a periodic reconciliation of costs for covered services benchmarked against the capitation rate that would have been paid for that population. Any resulting savings in excess of the administrative advance is distributed to the PSN. Excluded Populations: Under 21 residing in a Nursing Facility or ICF/MR. Community mental health services are provided in area 6 only. Reimbursement is varied throughout the program. Some vendors are paid on a per member per month basis, others are paid on a nurse FTE basis, and some are paid based on contract deliverables.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement

-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
-Disenrollment Survey
-MCO Member Satisfaction Surveys

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta Blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of low birth weight infants

-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Claims payable and IBNR by line of business
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Expenses by line of business
-Medical and Hospital expenses
-Medical loss ratio
-Net income
-Net worth
-Revenue by line of business
-State minimum reserve requirements
-Total assets
-Total liabilities
-Total revenue

Beneficiary Characteristics:

-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Use of Services/Utilization:

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary

Health Plan/ Provider Characteristics:

None

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Breast cancer treatment
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Coronary artery disease treatment
-Depression management

-Diabetes management/care
-Domestic violence
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hepatitis B screening and treatment
-Hypertension management
-Lead toxicity
-Pharmacy management
-Pregnancy Prevention
-Pre-natal care
-Referral for Cervical cancer screening
-Sexually transmitted disease screening
-Sexually transmitted disease treatment
-Sickle cell anemia management
-Treatment of myocardial infraction
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:

-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:

None

EQRO Name:

-None

EQRO Organization:

-None

EQRO Mandatory Activities:

-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities:

None

Pay for Performance (P4P)

Implementation of P4P:

The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:

None

Population Categories Included:

None

Rewards Model:

None

Clinical Conditions:

None

Measurement of Improved Performance:

None

Initial Year of Reward:

Not Applicable

Evaluation Component:

The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

FLORIDA

Managed Health Care

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

- -Consumer Self-Report Data (see below for details)
- -Enrollee Hotlines
- -Monitoring of PIHP Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -PIHP Standards
- -Provider Data

Consumer Self-Report Data:

- -Patient Satisfaction Survey

Use of Collected Data:

- -Beneficiary Plan Selection
- -Contract Standard Compliance
- -Fraud and Abuse
- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

Use of HEDIS:

- -The State DOES NOT use any of the HEDIS measures
- -The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Performance Measures

Process Quality:

- -Adolescent immunization rate
- -Adolescent well-care visit rate
- -Cervical cancer screening rate
- -Comprehensive report on child health check-up
- -Dental services
- -Diabetes medication management
- -Emergency room visits
- -Frequency of on-going prenatal care
- -Immunizations for two year olds
- -Influenza vaccination rate
- -Initiation of prenatal care - timeliness of
- -Well-child care visit rates in 3,4,5, and 6 years of life
- -Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:

- -Patient satisfaction with care

Access/Availability of Care:

- -Average distance to PCP
- -Average wait time for an appointment with PCP
- -Children's access to primary care practitioners
- -Ratio of PCPs to beneficiaries

Use of Services/Utilization:

- -Drug Utilization
- -Emergency room visits/1,000 beneficiary
- -Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:

- -Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

Health Plan/ Provider Characteristics:

- -Board Certification
- -Provider turnover

Beneficiary Characteristics:

- -Beneficiary need for interpreter
- -Information of beneficiary ethnicity/race
- -Information on primary languages spoken by beneficiaries
- -Percentage of beneficiaries who are auto-assigned to PIHPs
- -PIHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
None

Non-Clinical Topics:
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-None

EQRO Organization:
-None

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Monitoring of PAHP Standards
-PAHP Standards

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

FLORIDA
Managed Health Care

Quality Oversight Activities:
- -Consumer Self-Report Data
- -Enrollee Hotlines
- -Focused Studies
- -Ombudsman
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

Consumer Self-Report Data:
- -CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
  - Adult with Special Needs Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child Medicaid SSI Questionnaire
  - Child with Special Needs Questionnaire

Use of Collected Data:
- -Beneficiary Provider Selection
- -Contract Standard Compliance
- -Fraud and Abuse
- -Health Services Research
- -Monitor Quality Improvement
- -Primary Care Case Management Fee
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Provider Profiling
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

Performance Measures

Process Quality:
- -Asthma care - medication use
- -Check-ups after delivery
- -Diabetes management/care
- -Frequency of on-going prenatal care
- -HIV/AIDS care
- -Immunizations for two year olds
- -Initiation of prenatal care - timeliness of
- -Pregnancy Prevention
- -Well-child care visit rates in 3, 4, 5, and 6 years of life
- -Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- -Patient satisfaction with care
- -Percentage of low birth weight infants

Access/Availability of Care:
- -Adult access to preventive/ambulatory health services
- -Average distance to primary care case manager
- -Average wait time for an appointment with primary care case manager
- -Children's access to primary care practitioners
- -Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
- -Average cost per patient for a period of time
- -DME/100 beneficiaries
- -Emergency room visits/100 beneficiaries
- -Inpatient admissions/100 beneficiaries
- -Lab and x-ray procedures/100 beneficiaries
- -Office visit/100 beneficiaries
- -Outpatient visits/100 beneficiaries
- -Physician referrals/100 beneficiaries
- -Therapies/100 beneficiaries

Provider Characteristics:
- -Board Certification

Beneficiary Characteristics:
- -Information of beneficiary ethnicity/race
- -Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics:
- -Adolescent Immunization
- -Adolescent Well Care/EPSDT
- -Asthma management
- -Breast cancer screening (Mammography)
- -Cervical cancer screening (Pap Test)
- -Child/Adolescent Dental Screening and Services
- -Child/Adolescent Hearing and Vision Screening and Services
- -Childhood Immunization
- -Cholesterol screening and management

Non-Clinical Topics:
- -Availability of language interpretation services

-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Coronary artery disease treatment
-Depression management
-Diabetes management
-Hepatitis B screening and treatment
-HIV Status/Screening
-HIV/AIDS Prevention and/or Management
-Hypertension management
-Lead toxicity
-Medical problems of the frail elderly
-Pre-natal care
-Sexually transmitted disease screening
-Sexually transmitted disease treatment
-Sickle cell anemia management
-Treatment of myocardial infraction
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

FLORIDA
Prepaid Mental Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Kaleema Muhammed
Florida Agency for Health Care Administration
(850) 414-6249

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 31, 1996

Implementation Date:
March 01, 1996

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Outpatient Hospital, Mental Health Rehabilitation, Mental Health Support, Mental Health Targeted Case Management

Contractor Types:
-Partnership between private managed care and local community MH inc.
-PIHP subcontracting with local community health providers and an Administrative service

Allowable PCPs:
-Psychiatrists
-Licensed Psychologists
-Licensed Mental Health Practitioner

Enrollment

FLORIDA
Prepaid Mental Health Plan

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-SOBRA CHILDREN
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Medicare Dual Eligibles
-Medically Needy
-Retroactive Eligibility
-Children admitted to a residential group care facility designated by Medicaid
-Adults who are admitted to services under a Florida Assertive Community Treatment Team
-Children listed in the HomeSafeNet Database

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Community-based care providers
-Department of Juvenile Justice
-Family Safety Program
-Florida Department of Children and families
-Forensic/Corrections System
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Health, Inc.

Florida Health Partners, Inc.

FLORIDA

Prepaid Mental Health Plan

ADDITIONAL INFORMATION

Medicaid recipients who do not voluntarily choose a managed care plan are mandatorily assigned. Recipients who choose or are mandatorily assigned to Medipass are automatically enrolled in the Prepaid Mental Health Plan. Children who are admitted to community placements designated by the Department of Juvenile Justice or the Child Welfare system are disenrolled from the Prepaid Mental Health Plan upon admission and then re-enrolled upon returning to the community. Children who are admitted to a Statewide Inpatient Psychiatric Program (SIPP) are also disenrolled from the PMHP upon admission and re-enrolled upon returning to the community. Adults admitted to Florida Assertive Community Foster Care Children are enrolled mandatorily in Areas 1 and 6. Recipients receiving Florida Assertive Community Treatment services are disenrolled from the PMHP and re-enrolled upon discontinuance of this service.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:

-Consumer/Beneficiary Focus Groups
-State-approved Survey

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

None

Validation - Methods:

-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

State conducts general data completeness assessments:

Yes

- -Medicaid Eligibility
- -Plan Enrollment
- -Diagnosis Codes
- -Procedure Codes
- -Revenue Codes
- -Age-appropriate diagnosis/procedure

Performance Measures

Process Quality:

-Coordination of mental health care with primary care
-Follow-up after hospitalization for mental illness
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality:

-Change in level of functioning
-Patient satisfaction with care

Access/Availability of Care:

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:

None

Health Plan/ Provider Characteristics:

-Board Certification
-Credentials and numbers of professional staff
-Languages Spoken (other than English)

Beneficiary Characteristics:

None

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Coordination of primary and behavioral health care
-Coordination of Substance Abuse and Mental Health Care
-Depression management

Non-Clinical Topics:

-Availability and access to specialty therapies
-Availability of language interpretation services

Standards/Accreditation

PIHP Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Non-Duplication Based on Accreditation:

None

EQRO Name:

-None

FLORIDA
Prepaid Mental Health Plan

EQRO Organization:

-Not Applicable

EQRO Mandatory Activities:

-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

FLORIDA

Statewide Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:

Barbara Butler-Moore
Florida Agency for Health Care Administration
(850) 410-0566

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 23, 1998

Implementation Date:
April 01, 1999

Waiver Expiration Date:
December 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

This program is a fee-for-service per diem all inclusive rate.

GEORGIA
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Lynette Baskette
Department of Community Health/Division of Medical
(404) 463-8571

State Website Address:

http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 08, 1999

Implementation Date:
October 01, 1997

Waiver Expiration Date:
December 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Lock-In Provision:
Does not apply because State only contracts with one

managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

State contracts with a single broker in each of the states 5 non-emergency transportation regions to coordinate and provide non-emergency transportation services statewide.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

GEORGIA
Non-Emergency Transportation Broker Program

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections - Submission Specifications:
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Accuracy Audits

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Type of Service

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Record Audits

Use of Services/Utilization:
-Utilization by Type

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

GEORGIA
Preadmission Screening and Annual Resident Review (PASARR)

CONTACT INFORMATION

State Medicaid Contact:

Maya Carter
Department of Community Health/Division of Medical
(404) 657-5466

State Website Address:

http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 01, 1994

Implementation Date:
November 01, 1994

Waiver Expiration Date:
September 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Inpatient Mental Health Services, Mental Health/Mental Retardation

Contractor Types:
-Private Nursing Homes

Allowable PCPs:
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis
-Psychologists
-Clinical Social Workers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

GEORGIA
Preadmission Screening and Annual Resident Review (PASARR)

Subpopulations Excluded from Otherwise Included Populations:
-American Indian/Alaskan Native
-Medicare Dual Eligibles
-Poverty Level Pregnant Women
-Reside in ICF/MR
-Participate in HCBS Waiver
-Special Needs Children (State defined)
-Enrolled in Another Managed Care Program

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Preadmission Screening and Annual Resident Review (PASARR)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-Ombudsman
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Standards/Accreditation

PIHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-OASYS

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

IDAHO

Healthy Connections

CONTACT INFORMATION

State Medicaid Contact:

Rinda Mitchell
Bureau of Medicaid Policy
(208) 364-1985

State Website Address:

http://www2.state.id.us/medicaid/index.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
November 26, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
September 30, 2006

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Flu shots, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Podiatry, Standard/HIV Testing and Treatment, Transportation, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

Enrollment

IDAHO

Healthy Connections

Populations Voluntarily Enrolled:

- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Foster Care Children
- -TITLE XXI SCHIP
- -Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

- -Medicare Dual Eligibles
- -Have Existing Relationship With a Non-participating PCP
- -Live in a Non-participating County
- -Retro-Eligibility Only
- -Reside in Nursing Facility or ICF/MR
- -Eligibility Period Less Than 3 Months
- -If travel > 30 Minutes or 30 Miles

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:

- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Foster Care Children
- -TITLE XXI SCHIP
- -Medicare Dual Eligibles

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Aging Agency
- -Developmental Disabilities Agency
- -Education Agency
- -Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections

ADDITIONAL INFORMATION

IDAHO

Healthy Connections

Case management fee per member per month. Childhood immunization is provided by the District Health Department. The beneficiaries that are under the Benchmark Package (covers basic and enhance plans for Medicaid coverage coming out of Medicaid Reform) are mandatorily enrolled. Enrollment is mandatory in 39 of our 44 counties and voluntary in the remaining 6 counties.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation

Performance Measures

Process Quality:
None

Access/Availability of Care:
-24/7 access to live Health Care Professional
-Average wait time for an appointment with primary care case manager

Provider Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-ER usage

Beneficiary Characteristics:
-Disenrollment rate
-Disenrollment reasons

INDIANA

Hoosier Healthwise

CONTACT INFORMATION

State Medicaid Contact:

Ginger Brophy
Indiana Family and Social Services Administration
(317) 232-4345

State Website Address:

http://www.in.gov/fssa/hoosier_healthwise/index.ht

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
AmeriChoice - A United Healthgroup Company

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 13, 1993

Implementation Date:
July 01, 1994

Waiver Expiration Date:
September 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Podiatry, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Internists
-Obstetricians/Gynecologists
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

- -Enrolled in Another Managed Care Program
- -Illegal Aliens
- -Refugees
- -Spend Down
- -Medicare Dual Eligibles
- -Reside in Nursing Facility or ICF/MR
- -Participate in HCBS Waiver

Medicare Dual Eligibles Included:
None

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Surveys medical needs of enrollee to identify members of these groups
- -Uses combined enrollment form at certain locations to identify members of the group.

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Caresource Indiana
Managed Health Services (MHS)
Molina Health Care
Harmony Health Plans of Indiana
MDwise

ADDITIONAL INFORMATION

Inpatient psychiatric hospital and outpatient pyschiatric services are generally carved-out. However, when these services are provided by an acute care hospital or a PCP, they are included. The same coverage condition applies to inpatient and outpatient substance abuse services.

QUALITY ACTIVITIES FOR MCO/HIO

INDIANA

Hoosier Healthwise

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of Collected Data:

-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:

-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:

Yes

Performance Measures

INDIANA
Hoosier Healthwise

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast Cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Low birth-weight baby
-Pre-natal care
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-E,P & P Consulting , Inc.

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of MCO reported performance data
-Validation of performance improvement projects

EQRO Optional Activities:
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters
-Validation of encounter data

Pay for Performance (P4P)

INDIANA
Hoosier Healthwise

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
None

Clinical Conditions:
None

Initial Year of Reward:
Not Applicable

Program Payers:
None

Rewards Model:
None

Measurement of Improved Performance:
None

Evaluation Component:
Not Applicable

INDIANA
Medicaid Select

CONTACT INFORMATION

State Medicaid Contact:	Ginger Brophy Office of Medicaid Policy and Planning (317) 232-4345
State Website Address:	http://www.medicaidselect.com/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
AmeriChoice - A United Health Group Company

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 22, 2002

Implementation Date:
January 01, 2003

Waiver Expiration Date:
September 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Obstetricians/Gynecologists
-Internists
-Any Physician Specialist
-Pediatricians
-General Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

-Children Receiving Adoption Assistance
-Room and Board Assistance (RBA)
-Ticket to Work (MedWorks)
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Wards or Foster Children
-Medicare Duel Eligible that do not qualify for a non-Medicare Aid Category
-TANF and related Adults and Children
-Breast and Cervical Cancer Aid Categories
-Spend-down
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Program designed for disabled, blind and aged.
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medicaid Select

ADDITIONAL INFORMATION

Medicaid Select program includes disease management as one of the included services.

INDIANA
Medicaid Select

FFS with a $4.00 Administration Fee per Member.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Members and Providers Satisfaction Surveys
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality:
None

Access/Availability of Care:
None

Provider Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction for the ICDMP
-Patient satisfaction with care

Use of Services/Utilization:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Clinical Topics:
-Asthma management
-Congestive Heart Failure Management
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics:
None

IOWA

Iowa Plan For Behavioral Health

CONTACT INFORMATION

State Medicaid Contact:

Dennis Janssen
Department of Human Services
(515) 725-1136

State Website Address:

http://www.dhs.state.ia.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 1999

Implementation Date:
January 01, 1999

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Ambulance, Clinic, Detoxification, Enhanced Services, Home Health, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Outpatient, Outpatient Substance Use Disorders, X-ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles

-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

-Age 65 or older
-Medically Needy with cash spenddown
-Reside in State Hospital-School
-Eligible for Limited Benefit Package

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

No

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
None

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications:
-Guidelines for frequency of encounter data submission

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

State conducts general data completeness assessments:
No

Standards/Accreditation

PIHP Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Iowa Foundation for Medical Care

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

KENTUCKY

Human Service Transportation

CONTACT INFORMATION

State Medicaid Contact:

Neville Wise
Division of Administration & Financial Affairs
(502) 564-8196

State Website Address:

http://chs.state.ky.us/dms/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 01, 1996

Implementation Date:
June 01, 1998

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
SLMB, QI, and QDWI

Medicare Dual Eligibles Excluded:
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

ADDITIONAL INFORMATION

Title XXI SCHIP is included up to 150% of FPL.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Track Health Service provision

-Ombudsman

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Comparsion to plan claims payment data
-Per member per month analysis and comparisons across PAHPs

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

MICHIGAN
Comprehensive Health Plan

CONTACT INFORMATION

State Medicaid Contact:	Cheryl Bupp Michigan Department of Community Health (517) 241-7933
State Website Address:	http://www.michigan.gov/mdch

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Michigan Enrolls

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 30, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Intermittent or Short-term Restorative or Rehab Skilled Nursing Care, Laboratory, Maternal and infant service, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Prosthetics and Orthotics, Speech Therapy, Transplant, Transportation, Vision, X-Ray

Allowable PCPs:
-Physician assistants
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners

Enrollment

MICHIGAN
Comprehensive Health Plan

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- -Reside in Nursing Facility or ICF/MR
- -Participate in HCBS Waiver
- -Enrolled in Another Managed Care Program
- -Spenddown
- -Court Wards
- -Kosovo Refugees
- -Persons enrolled in CSHCS
- -Medicare Dual Eligibles
- -Other insurance (HMO or PPO only)
- -Persons without full medicaid coverage, including those in the state medical program or pluscare

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Children who age out of CSHCS are identified to health plans by staff monthly

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Education Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency
- -Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Cape Health Plan
Great Lakes Health Plan
HealthPlus Partners, Inc.
McLaren Health Plan
Molina Healthcare of Michigan
Community Choice Michigan
Health Plan of Michigan
M-Caid HMO
Midwest Health Plan
Omnicare Health Plan

MICHIGAN
Comprehensive Health Plan

Physicians Health Plan of Mid-Michigan - Family Care
Priority Health Government Programs, Inc.
Upper Penninsula Health Plan
Physicians Health Plan of Southwest Michigan
Total Health Care

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- -Accreditation for Deeming (see below for details)
- -Accreditation for participation, member or applied for membership
- -Complaint and Grievance Monitoring
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -EQR and HEDIS
- -MCO Standards
- -Monitoring of MCO Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data
- -Timely and Accurate Provider File Submissions
- -Timely and Compliant Claims Reporting

Consumer Self-Report Data:
- -CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child Medicaid SSI Questionnaire

Use of Collected Data:
- -Beneficiary Plan Selection
- -Contract Standard Compliance
- -Data Mining
- -Health Services Research
- -Monitor quality improvement efforts
- -Monitor service provision
- -Program Evaluation
- -Public Reporting/Incentives
- -Regulatory Compliance/Federal Reporting

Use of HEDIS:
- -The State uses SOME of the HEDIS measures listed for Medicaid
- -The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- -State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
- -Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- -Incentives/sanctions to promote completeness, accuracy and timeliness of encounter data submission
- -Requirements for data validation
- -Requirements for MCOs to collect and maintain encounter data
- -Specifications for the submission of encounter data to the Medicaid agency
- -Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
- -ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- -NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Collections: Submission Specifications:
- -837 Implementation Guidelines
- -Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- -Deadlines for regular/ongoing encounter data submission(s)
- -Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
- -Guidelines for frequency of encounter data submission
- -NCPDP Manual
- -Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
- -Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- -Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Bill Type
-County
-Place of Service
-Zip code

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Appropriate testing for children with pharyngites
-Appropriate treatment for children with URI
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood immunization rates
-Chlamydia screening rates
-Controlling high blood pressure
-Diabetes medication management
-Prenatal and Postpartum care rates
-Smoking prevention and cessation

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult access to preventative/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Adolescent well-care visit rates
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Improvement Projects

Project Requirements:
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Access to Care Children and Adult
-Lead toxicity

Non-Clinical Topics:
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

MICHIGAN
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Standards/Accreditation

MCO Standards:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-URAC

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Name:
-Health Services Advisory Group (HSAG)

EQRO Mandatory Activities:
-Quality, access and timelines
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of Performance Measures

EQRO Optional Activities:
-CAHPS - Consumer Survey
-Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Accreditation Status
Asthma
Blood Lead
Cardiac Care
Childhood immunizations
Consumer Satisfaction
Diabetes
Prenatal Care
Well-child visits

Initial Year of Reward:
2001

Program Payers:
Medicaid is the only payer

Rewards Model:
Member incentives in the MCO P4P program
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing levels of technology adoption
Assessing patient satisfaction measures
Assessing the adoption of systematic quality improvement processes
Assessing the timely submission of complete and accurate electronic encounter/claims data
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

MINNESOTA
Consolidated Chemical Dependency Treatment Fund

CONTACT INFORMATION

State Medicaid Contact:	Christine Bronson Minnesota Department of Human Services (651) 431-2914
State Website Address:	www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
March 27, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

County Case Manager - Fee-for-Service

Service Delivery

Included Services:
Extended Rehabilitation (Extended Care), Inpatient Substance Use Disorders, Outpatient Substance Use Disorders, Transitional Rehabilitation (Halfway House)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (BBA defined)
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Aged and Related Populations
-American Indian/Alaskan Native
-Foster Care Children
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

None

ADDITIONAL INFORMATION

All Medicaid recipients are eligible to participate in this program.

MISSISSIPPI

Mississippi Non-Emergency Transportation Program

CONTACT INFORMATION

State Medicaid Contact:

Brian Smith
NET Program
(601) 576-5940

State Website Address:

www.MS.TRANSPORTATION

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Initial Waiver Approval Date:
April 11, 2003

Implementation Date:
April 11, 2003

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

This program enables the State of Mississippi to selectively contract with various types of transportation providers to provide non-emergency transportation service to Medicaid beneficiaries. The State currently has provider agreements with group, individual and mass transit providers.

MISSOURI

MC+ Managed Care/1915b

CONTACT INFORMATION

State Medicaid Contact:	Shelley Farris Department of Social Services, Division of Medical Svcs. (573) 751-5178
State Website Address:	http://www.missouri.gov

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1995

Implementation Date:
September 01, 1995

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Care, Ambulatory Surgical Care, Case Management, Clinic - FQHC/RHC, Comprehensive Day Rehabilitation, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Prenatal Case Management, Transportation, Vision, X-Ray

Allowable PCPs:
-PCP Teams
-PCP Clinics
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

MISSOURI
MC+ Managed Care/1915b

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- -Participate in HCBS Waiver
- -Enrolled in Another Managed Care Program
- -AIDS Waiver program participants
- -Permanently and totally disabled individuals
- -Aid to the Blind and Blind Pension Individuals
- -Children with Developmental Disabilities Program
- -Medicare Dual Eligibles
- -Reside in Nursing Facility or ICF/MR
- -Presumptive Eligibility Program for Pregnant Women
- -American Indian/Alaskan Native
- -Presumptive Eligibility for Children
- -Individuals eligible under Voluntary Placement Agreement for Children

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Foster Care Children
- -MC+ for Pregnant Women
- -Children in the Legal Custody of Department of Social Services
- -Mentally Retarded Developmentally Disabled (MRDD) Waiver participants
- -Special Needs Children (State defined)
- -Poverty-Level Pregnant Women

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program
-Recipients who have access to transportation at no cost to the recipient
-Recipients who have access to transportation through a public entity
-Recipients enrolled in the Hospice program

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Data Match with Other State Agencies
-Health Risk Assessment
-Helpline
-MCO uses ER Encounters
-MCOs use Drug Usage

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Other State Agencies as necessary
-Public Health Agency

-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-Reviews grievances and appeals to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

-Social Security Administration

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of Kansas City, Blue Advantage+ Plus

Community Care Plus

Family Health Partners

FirstGuard

HealthCare USA

Mercy Health Plans

Missouri Care

Non-Emergency Medical Transportation (NEMT)

ADDITIONAL INFORMATION

PCP Clinics can include FQHCs/RHCs. Vision services for members 21 and over are limited to one eye examination every two years, services related to trauma or treatment of disease/medical condition, and one pair of eyeglasses following cataract surgery. Vision services for pregnant women 21 and over are limited to one eye examination per year, services related to trauma or treatment of disease/medical condition, and one pair of eyeglasses following cataract surgery. Dental services for members 21 and older are limited to trauma to the mouth or teeth as a result of injury. Dental services for pregnant women 21 and older are limited to dentures and trauma to the mouth or teeth as a result of injury. All other vision and dental services are carved out of the MC+ Managed Care Program and are covered through the MC+ Fee-For-Service Program. Allowable PCPs: PCP clinics can include FQHCs and RHCs. Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI), who meet the SSI medical disability definition, or who receive adoption subsidy may choose to enroll or voluntarily disenroll from the MC+ Managed Care Program at any time. Enrollment is mandatory for special needs children but individuals may request to opt out. HealthCare USA health plan participates in Eastern, Central, and Western Regions. MO is a 209(b) State and has no specific eligibility categories for the special needs populations.

Transportation PAHP: Recipients enrolled in a MC+ managed care health plan receive Non-Emergency Medical Transportation (NEMT) from their MCO. All other eligible recipients statewide receive services from the NEMT broker. Individuals with special health care needs include those with needs due to physical and/or mental illnesses, foster care children, homeless individuals, individuals with serious and persistent mental illness and/or substance abuse, and individuals who are disabled or chronically ill with developmental or physical disabilities.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards
-Monitoring of MCO Standards
-Network Data
-Ombudsman (Western and Eastern Regions only)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
    Child Medicaid AFDC Questionnaire

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid

-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-See Attachment 1 for additional Data Accuracy Checks

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Ambulatory Care
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Chlamdyia screening in women
-Dental services
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Mental Health Utilization
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Missouri Department of Insurance Monitors and Tracks Health Plan Stability/Financial/Cost of Care

Beneficiary Characteristics:

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Use of Services/Utilization:

-Emergency room visits/1,000 beneficiaries under the age of 19
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of PCP visits per beneficiary
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:

-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing

Non-Clinical Topics:

-Access to primary care
-Customer Service and Prior Authorization

Clinical Topics:

-ADHD
-Asthma management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care

Standards/Accreditation

MCO Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:

None

EQRO Organization:

-Quality Improvement Organization (QIO)

Accreditation Required for Participation:

None

EQRO Name:

-Behavioral Health Concepts (BHC)

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

-Validation of performance measures

EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
A subset of MCO members, defined by beneficiary age

Clinical Conditions:
Childhood immunizations
Well-child visits

Initial Year of Reward:
2001

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

Measurement of Improved Performance:
State measures MCO achievement in reaching established standards of outcome measures

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-None

Consumer Self-Report Data:
None

Use of Collected Data:
-Does Not Use the Data Collected

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

MONTANA

Montana Passport to Health

CONTACT INFORMATION

State Medicaid Contact:

Mary Noel
MT Dept of Public Health and Human Serivces
(406) 444-4146

State Website Address:

http://www.dphhs.mt.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
Policy Studies Incorporated

For All Areas Phased-In:
No

Guaranteed Eligibility:
1 month guaranteed eligibility month guaranteed eligibility

Initial Waiver Approval Date:
August 31, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
March 31, 2008

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Dialysis, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home and Community Based Waiver, Home Health, Home Infusion Therapy, Home Personal Attendant, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Geriatrics
-Pediatricians
-Nephrologist

MONTANA
Montana Passport to Health

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)
-Team Care

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Medically Needy
-Area without Managed Care
-Subsidized Adoption
-Only Retroactive Eligibility

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport to Health

MONTANA

Montana Passport to Health

ADDITIONAL INFORMATION

Program includes a $3.00 case management fee to the Primary Care Provider (PCP). Program includes a $6.00 case management fee to the PCP for Team Care clients. Team Care clients are those who have been identified as mis-utilizing Medicaid services. They are mandated into the Passport Program. The Team Care population can include clients who are dually eligible for Medicaid and Medicare.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-State-developed Survey

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal

Performance Measures

Process Quality:

-Immunizations for two year olds

Access/Availability of Care:

-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Provider Characteristics:

None

Health Status/Outcomes Quality:

-Patient satisfaction with care

Use of Services/Utilization:

None

Beneficiary Characteristics:

None

Performance Improvement Projects

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Prevention of Influenza
-Well Child Care/EPSDT

Non-Clinical Topics:

-Availability of language interpretation services
-Native American Adults access to preventive/ambulatory health services
-Native American Children access to to Primary Care Practitioners

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

CONTACT INFORMATION

State Medicaid Contact:

David Cygan
Nebraska Medicaid
(402) 471-9050

State Website Address:

http://www.hhs.state.ne.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Nebraska Health Connection/Access Medicaid

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 05, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native
-Special Needs Children (State defined)

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

Subpopulations Excluded from Otherwise Included Populations:

-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibles
-Transplant Recipients
-Medicare Dual Eligibles

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Presumptive Eligibility
-Transplant Recipients
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native
-Special Needs Children (State defined)

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Specialty Physician Case Management (SPCM) Program - Fee-for-Service

Service Delivery

Included Services:
Adult Substance Abuse Treatment, Client Assistance Program, Consultative Services, Crisis Response, Crisis Stabilization, Educational Activity, Enhanced Treatment Group Home, Home Health RN, Individualized Rehabilitative Services, Inpatient Hospital, Inpatient Mental Health, Intensive Case Management, Intensive Outpatient, Laboratory, Native American MH/SA, Outpatient Hospital, Outpatient Mental Health, Physician, Psychiatric Nursing, Respite Care, Transportation, Treatment Crisis Intervention, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Presumptive Eligibles
-Transplant Recipients
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the State Disability Program
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native
-Special Needs Children (State defined)
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Magellan Behavioral Health

Share Advantage

Primary Care Plus

ADDITIONAL INFORMATION

For PCCM, MCO, and Specialty Physician Case Management (SPCM), the State defines Special Needs Children as Blind/Disabled Children and Related Populations, Children Receiving Title V Services and State Wards. Blind/Disabled Children and Related Populations
Children Receiving Title V Services
State Wards Blind/Disabled Children and Related Populations
Children Receiving Title V Services
State Wards Blind/Disabled Children and Related Populations
Children Receiving Title V Services
State Wards

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
-State-developed Survey

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements:

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Submission of encounter data to the State in standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:

-Average distance to PCP
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:

None

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Use of Services/Utilization:

None

Health Plan/ Provider Characteristics:

-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed

Clinical Topics:

-Breast cancer screening (Mammography)
-Pre-natal care

by the State Medicaid agency

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
-Medicare+ Choice Accreditation
-NCQA (National Committee for Quality Assurance)

EQRO Organization:
-QIO-like entity

Accreditation Required for Participation:
-Department of Insurance Certification
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Nebraska Foundation for Medical Care

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Not Applicable

Consumer Self-Report Data:
None

Use of Collected Data:
None

QUALITY ACTIVITIES FOR OTHER

Quality Oversight Activities:
-Not Applicable

Use of Collected Data:
-Do Not Use the Data Collected

Consumer Self-Report Data:
None

NEW HAMPSHIRE

New Hampshire Medicaid Health Management Program

CONTACT INFORMATION

State Medicaid Contact:

Tiffany Fuller
Office of Medicaid Business and Policy
(603) 271-7303

State Website Address:

http://www.dhhs.state.nh.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 01, 2005

Implementation Date:
March 03, 2005

Waiver Expiration Date:
March 02, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Disease Management PAHP - Non-risk Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson Health Solutions

ADDITIONAL INFORMATION

Reimbursement based on per member per month structure.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Provider Data

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
-Vendor Developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

NEW JERSEY

NJ FamilyCare - 1915(b)

CONTACT INFORMATION

State Medicaid Contact:

Jill Simone, M.D.
Office of Managed Health Care
(609) 588-2705

State Website Address:

http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
Affiliated Computer Services, Incorporated (ACS)

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 18, 2000

Implementation Date:
October 01, 2000

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Audiology, Chiropractor, Dental, Durable Medical Equipment, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid Service, Home Health, Hospice, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Supplies, Optical Appliances, Optometry, Organ Transplants, Outpatient Hospitals, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatry, Post-acute Care, Preventive Health Care, Counseling, and Health Prevention, Prosthetics, Orthotics, Rehabilitation and Special Hospitals, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Family Practitioners
-Physician Assistants
-Certified Nurse Specialists
-Pediatricians
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Nurse Practitioners

Enrollment

NEW JERSEY
NJ FamilyCare - 1915(b)

Populations Voluntarily Enrolled:

-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Individuals institutionalized in an inpatient psychiatric facility
-Full-time students attending school but resides outside the country
-Medically needy and presumptive eligibility beneficiaries
-Individuals with eligibility period that is only retroactive
-Individuals in out-of-state placements
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:

-Non duals DDD/CCW children <19
-Foster Care Children
-Blind/Disabled Children and Related Populations
-Special Needs Children (BBA defined)
-Aged and Related Populations

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Division of Youth and Family Services Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.

AMERIGROUP New Jersey, Inc.

Health Net of New Jersey, Inc.
University Health Plans, Inc.
Horizon NJ Health

ADDITIONAL INFORMATION

Lock-in Period: 12-month lock-in is for AFDC/TANF. There is no lock-in for SSI, Aged, Blind, Disabled, DDD or DYFS populations. Division of Developmental Disabilities Community Care Waiver (DDD/CCW) is a community care waiver which is a Medicaid program that allows the State to waiver certain Federal Medicaid eligibility cariteria for individuals who meet eligibility for the Division of Developmental Disabilities services, reside in the community, and require an ICF/MR level of care.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-After Hours Beneficiary Call-in Sessions
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-Independent Assessment
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Test 24/7 PCP Availability
-Utilization Review

Consumer Self-Report Data:

-Disenrollment Survey

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

None

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency

distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Comparison of reported changes to reasonable and customary fees.

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical Cancer Screening
-Check-ups after delivery
-Childhood Immunizations
-Comprehensive Diabetes Care
-Lead screening rate
-Quality and utilization of dental services
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Lead Toxicity Study

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries
-Ratio of pharmacies to number of beneficiaries

Use of Services/Utilization:
-Average inpatient length of stay
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient days per 1000 members
-Pharmacy services per member
-Physician visits per 1000 members

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

NEW JERSEY

NJ FamilyCare - 1915(b)

Beneficiary Characteristics:
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Well Care/EPSDT
-Asthma management
-Birth Outcomes
-Child/Adolescent Dental Screening and Services
-Diabetes management
-Lead Screenings
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:

-Children's access to primary care practitioners
-Encounter Data Improvement
-Hospital Appeals and Denials

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:
-Department of Banking and Insurance

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Healthcare Quality Strategies, Inc. (HQSI)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Conduct studies on access that focus on a particular aspect of clinical and non-clinical services
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record review
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
N/A

Population Categories Included:
N/A

Rewards Model:
N/A

Clinical Conditions:
N/A

Measurement of Improved Performance:
N/A

NEW JERSEY
NJ FamilyCare - 1915(b)

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

NEW MEXICO
NEW MEXICO SALUD!

CONTACT INFORMATION

State Medicaid Contact:	Alana Reeves, PhD. HSD Medical Assistance Division (505) 827-3131
State Website Address:	http://www.state.nm.us/hsd/mad/salud.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 13, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulatory Surgical Center Services, Anesthesia Services, Audiology, Case Management, Dental, Dialysis, Durable Medical Equipment, Emergency Room Services, EPSDT, EPSDT Personal Care, EPSDT Private Duty Nursing, Family Planning, Federally Qualified Health Centers, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Medical Services Providers, Midwife, Non-IEP School Based Services, Nutritional Services, Outpatient Hospital, Pharmacy, Podiatry, Pregnancy Termination, Prosthetics and Orthodics, Rehabilitation Services, Reproductive Health Services, Rural Health Clinics, Transplant Services, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Indian Health Service (IHS) Providers
-Physician Assistants
-Gerontologists
-Certified Nurse Practitioners
-Certified Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

NEW MEXICO
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Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Clients in the Breast and Cervical Cancer Program
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Medicaid Clients in the Health Insurance Premium Program (HIPP)
-Children and Adolescents in Out-of-State Foster Care or Adoption Placement
-Family Planning Waiver Clients

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women
-Home and Community Based Waiver

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

NEW MEXICO SALUD!

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
IMD Services, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Pharmacy

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Psychiatrists
-Psychologists
-Clinical Social Workers

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Poverty-Level Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Individuals identified by service utilization, clinical assessment, or diagnosis
-Referal by family, a public, or community program

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging and Long Term Services Department
-Children, Youth, and Families Department
-Department of Health

-Uses eligibility data to identify members of these groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Lovelace Community Health Plan
Presbyterian Salud!
Molina Healthcare of New Mexico
ValueOptions of New Mexico

ADDITIONAL INFORMATION

ValueOptions of New Mexico provides behavioral services through BH providers. Lovelace Community Health Plan, Molina Health Care and Presbyterian Salud! provide physical health services and those BH services provided by non-BH provider/practitioners. Native Americans within other covered categories have the option of choosing to participate in managed care due to tribal agreements. They require a broad range of primary, specialized medical, behavioral health and related services. ISCHNs are individuals who have or are at increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or low to severe functional limitation, and who also require health and related services of a type or amount beyond that required by other individuals. ISCHNs have on-going health conditions,high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targetting of individuals based on clinical justification and discontinuing targetted efforts when such efforts are no longer needed.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Challenge Pool Measures
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Tracking Measures

Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
    3.0
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
-MSIP

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)

-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Payment
-Plan Enrollment
-Procedure Codes
-Revenue Codes

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Depression management/care
-Diabetes medication management
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:

-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:

-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Provider payment timeliness
-State minimum reserve requirements

Beneficiary Characteristics:

-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization:

-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics:

-Board Certification

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NEW MEXICO SALUD!

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Depression management
-Diabetes management
-Pharmacy management
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:

-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:

-NCQA (National Committee for Quality Assurance)

EQRO Organization:

-Quality Improvement Organization (QIO)

Accreditation Required for Participation:

-NCQA (National Committee for Quality Assurance)

EQRO Name:

-New Mexico Medical Review Association

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:

-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:

A subset of MCO members, defined by disease and medical condition
Covers all MCO members

Clinical Conditions:

Asthma
Childhood immunizations
Depression
Diabetes
Well-child visits

Program Payers:

Medicaid is the only payer

Rewards Model:

Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs

Measurement of Improved Performance:

Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing the timely submission of complete and accurate electronic encounter/claims data

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Initial Year of Reward:
1997

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Network Data
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-State Managed Care Medicaid Quality Strategy
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment

State conducts general data completeness assessments:
Yes

-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

Performance Measures

Process Quality:
-Diabetes medication management
-Follow-up after hospitalization for mental illness

Access/Availability of Care:
-Ratio of mental health providers to number of beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PIHPs

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Use of Services/Utilization:
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements:
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Clinical Topics:
-Depression management

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

EQRO Name:
-New Mexico Medical Review Association(NMMRA)

NEW MEXICO
NEW MEXICO SALUD!

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

OREGON

Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Larry Daimler
Office of Medical Assistance Programs
(503) 945-6493

State Website Address:

www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

FFS Transportation Brokers - Fee-for-Service

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

The State contract with transportation brokers on a FFS basis. All enrollees under the Oregon Health Plan are enrolled in this program.

PENNSYLVANIA
Access Plus Program

CONTACT INFORMATION

State Medicaid Contact:

Kathy Willis
Pennsylvania Department of Welfare
(717) 772-6150

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
Affiliated Computer Services (ACS), LLC

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 2005

Implementation Date:
March 01, 2005

Waiver Expiration Date:
December 31, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

PCCM Provider - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Other Specialists Approved on a Case-by-Case Basis
-Specialist Who Meets Special Needs of Client
-Independent Medical/Surgical Clinic
-Hospital Based Medical Clinic

PENNSYLVANIA
Access Plus Program

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Foster Care Children
-Special Needs Children (State defined)
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-State Blind Pension Recipients
-Residence of State Institutions
-Enrolled in Long Term Care Capitated Program (LTCCP)
-Incarcerated Recipients
-Medicare Dual Eligibles
-Enrolled in Health Insurance Premium Payment (HIPP)

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Dual eligibles under 21

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Foster Care Children
-Special Needs Children (State defined)
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB
Dual Eligibles over 21

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Independent Medical/Surgical Clinic
-Hospital Based Medical Clinic
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Special Needs Children (State defined)
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Health Insurance Premium Payment Program
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Residence in a State Facility
-Special Needs Children (BBA defined)
-Enrolled in Long Term Care Capitated Program (LTCCP)
-Incarcerated Recipients
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Dual Eligibles under 21

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Asks advocacy groups to identify members of these groups
- -Department of Public Welfare Offices
- -Enrollment Contractor
- -Legislative Offices
- -Reviews complaints and grievances to identify members of these groups
- -Self-Referral
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses claims to identify special needs
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Aging Agency
- -Developmental Disabilities Agency
- -Education Agency
- -Juvenile Justice Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency
- -Social Services Agency
- -Substance Abuse Agency
- -Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Plus
Program

Disease Management
PAHP

ADDITIONAL INFORMATION

Enrollees are assigned to the Disease Management program if they have one of the following qualifying chronic diseases: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Congestive Heart Failure. However, enrollees can choose to opt out of this program. Special Needs Children is broadly defined as non-categorical to include all children. The Providers in the network are reimbursed on a FFS basis. The ACCESS Plus Contrator receives a capitation for EPCCM Services and capitation for Disease Management Services. Access Plus is the default program; with exceptions. If a voluntary managed care program is in a county with Access Plus, the recipient can choose which delivery system they want. If no choice is made, the recipient is auto-assigned to Access Plus. However, in counties where there is no voluntary managed care program, recipients are mandatorily enrolled into Access Plus. The reimbursement arrangement is Fee-For-Service (PMPNV Guaranteed Savings).

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

- -Accreditation for Participation (see below for details)
- -Consumer Self-Report Data (see below for details)
- -Consumer Surveys
- -Focused Studies
- -Monitoring of PAHP Standards
- -On-Site Reviews

Use of Collected Data:

- -Contract Standard Compliance
- -Data Mining
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting

-PAHP Standards
-Performance Measures (see below for details)
-Provider Surveys

Consumer Self-Report Data:
-Contractor developed survey for chronic illness satisfaction
-Contractor developed survey for satisfaction

-Target areas for new quality improvement activities

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Childhood access to preventive/ambulatory health services

Health Plan Stability/ Financial/Cost of Care:
-Administrative Costs
-Pay for performance reports on payouts and reserve and withhold
-Total revenue

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
-Chronic Care Satisfaction
-Health Status Reports from Contractor
-Patient satisfaction with care

Use of Services/Utilization:
-Call Abandonment
-Call Timeliness
-Emergency room visits/1,000 beneficiary

Health Plan/ Provider Characteristics:
-Geo Mapping Report
-Number of Providers Participating in Disease Management
-Number of Providers Following Standard Practice Guidelines for Chronic Illnesses

Standards/Accreditation

PAHP Standards:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Target New Areas for Quality Improvement

PENNSYLVANIA
Access Plus Program

Consumer Self-Report Data:
-Consumer Complaints
-State-developed Survey

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Adolescent well child visits
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Provider Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Call Abandonment
-Call Timeliness
-Emergency room visits/1,000 beneficiaries
-Hospital Readmission Rates
-Inpatient admissions/1,000 beneficiaries
-Number of field staff case manager visits for prenatal maternity care
-Number of OB/GYN visits per adult female beneficiary
-Number of telephonic case manager calls for prenatal maternity care

Beneficiary Characteristics:
None

Performance Improvement Projects

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Depression Screening
-Diabetes management
-Domestic violence
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Post-natal Care
-Pre-natal care
-Sexually transmitted disease screening
-Smoking prevention and cessation
-Treatment of myocardial infraction
-Well Child Care/EPSDT

Non-Clinical Topics:
-Availability of language interpretation services
-Children's access to primary care practitioners

PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact:

Patricia Jacobs
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Affiliated Computer Services (ACS), LLC

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 31, 1996

Implementation Date:
February 01, 1997

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

PENNSYLVANIA
HealthChoices

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-State Only Categorically and Medically Needy
-Special Needs Children (State defined)
-Poverty-Level Pregnant Women
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Monthly Spend Downs
-Medicare Dual Eligibles
-State Blind Pension Recipients
-Reside in Nursing Facility or ICF/MR
-Incarcerated Recipients
-Reside in a State Facility
-Enrolled in Long Term Care Capitated Program (LTCCP)
-Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Dual Eligibles under 21

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI
Dual Eligibles over 21

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Behavioral Health Rehab Services for Children and Adolescents, Case Management, Crisis, Detoxification, Family Based Services, Inpatient Mental Health Services, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders Services, Residential Substance Use Disorders Treatment Programs

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Monthly Spend Downs
-State Blind Pension Recipients
-Medicare Dual Eligibles
-Reside in Nursing Facility
-Incarcerated Recipients
-Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
-Residence in a State Facility
-Enrolled in a Long Term Care Capitated Program

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PENNSYLVANIA
HealthChoices

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Self Reported
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of Pennsylvania
County of Adams - Community Care Behavioral Health
County of Armstrong - Value Behavioral Health of PA
County of Berks - Community Care Behavioral Health
County of Butler - Value Behavioral Health of PA
County of Cumberland - Community Behavioral Healthcare Network of PA, Inc.
County of Delaware - Magellan Behavioral Health
County of Indiana - Value Behavioral Health of PA
County of Lawrence - Value Behavioral Health of PA
County of Lehigh - Magellan Behavioral Health
County of Northampton - Magellan Behavioral Health
County of Philadelphia - Community Behavioral Health
County of Westmoreland - Value Behavioral Health of PA
Gateway Health Plan, Inc.
Keystone Mercy Health Plan
Unison Health Plan / MedPLUS
Value Behavioral Health of PA (Greene County)
AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan
County of Allegheny - Community Care Behavioral Health
County of Beaver - Value Behavioral Health of PA
County of Bucks - Magellan Behavioral Health
County of Chester - Community Care Behavioral Health
County of Dauphin - Community Behavioral Healthcare Network of PA, Inc.
County of Fayette - Value Behavioral Health of PA
County of Lancaster - Community Behavioral Healthcare Network of PA, Inc.
County of Lebanon - Community Behavioral Healthcare Network of PA, Inc.
County of Montgomery - Magellan Behavioral Health
County of Perry - Community Behavioral Healthcare Network of PA, Inc.
County of Washington - Value Behavioral Health of PA
County of York - Community Care Behavioral Health
Health Partners of Philadelphia
Unison Health Plan
UPMC Health Plan, Inc./UPMC for You

ADDITIONAL INFORMATION

Skilled Nursing Facility is for the first 30 days. Special Needs Children: (state defined) Broadly defined non-categorical to include all children.

All consumers receiving behavorial health services are considered to be persons with special needs.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)

Use of Collected Data:
-Beneficiary Plan Selection

- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -MCO Standards
- -Monitoring of MCO Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

- -Contract Standard Compliance
- -Fraud and Abuse
- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

Consumer Self-Report Data:

-CAHPS
  3.0H adult and children

Use of HEDIS:

-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:

No

Performance Measures

PENNSYLVANIA
HealthChoices

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life
-Well-child care visits rates in 7, 9 or 11 years of age

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Number of years Health Plan in business and total membership
-Provider turnover

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are

Clinical Topics:
-Adolescent Pregnancy
-Asthma management
-Child/Adolescent Dental Screening and Services

required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

-Childhood Immunization
-Hypertension management
-Smoking prevention and cessation

Non-Clinical Topics:
-Adult's access to dental care
-Children's access to dental care

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Adolescent Well Care
Asthma
Breast Cancer Screening
Cervical Cancer Screening
Cholesterol Management
Controlling High Blood Pressure
Diabetes
Prenatal Care

Initial Year of Reward:
2006

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -Monitoring of PIHP Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -PIHP Standards
- -Provider Data

Use of Collected Data:
- -Contract Standard Compliance
- -Fraud and Abuse
- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

Consumer Self-Report Data:
- -Consumer/Family Satisfaction Team Survey
- -State-developed Survey

Use of HEDIS:
- -The State uses SOME of the HEDIS measures listed for Medicaid
- -The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
- -State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
- -Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- -Requirements for data validation
- -Requirements for PIHPs to collect and maintain encounter data
- -Specifications for the submission of encounter data to the Medicaid agency
- -Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
- -Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- -Deadlines for regular/ongoing encounter data submission(s)
- -Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
- -Guidelines for frequency of encounter data submission
- -Guidelines for initial encounter data submission
- -Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
- -UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
- -Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- -Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- -Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- -Medical record validation
- -Per member per month analysis and comparisons across PIHPs

PIHP conducts data accuracy check(s) on specified data elements:
- -Date of Service
- -Date of Processing
- -Date of Payment
- -Provider ID
- -Medicaid Eligibility
- -Plan Enrollment
- -Diagnosis Codes
- -Procedure Codes

State conducts general data completeness assessments:
Yes

-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:
-Follow-up after hospitalization for mental illness
-Residential Treatment Facility Care Remeasurement Study

Access/Availability of Care:
-Access to MH/SUD services within time and distance requirements
-Ratio of mental health providers to number of beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by category of service
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing MH/SUD services compared to estimated population w/MH/SUD need/illness.
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:

-Follow-up for D&A
-Follow-up for MH Hospital Discharge

Clinical Topics:

None

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-IPRO

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational

standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

TEXAS
NorthSTAR

CONTACT INFORMATION

State Medicaid Contact:

Lisa Ledbetter
Texas Health and Human Services Commision
(512) 491-1199

State Website Address:

http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Maximus Incorporated

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 1999

Implementation Date:
November 01, 1999

Waiver Expiration Date:
November 05, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Other-mostly FFS/some Risk Base

Service Delivery

Included Services:
Assertive Community Treatment Team, Crisis, Detoxification, Dual Diagnosis, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Residential Substance Use Disorders Treatment Programs, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCP

Enrollment

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Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Individuals Eligible as Medically Needy
- Individuals Receiving inpatient Medicaid IMD svs over age 65
- Qualified Medicare Beneficiaries
- Other Insurance
- Individuals receiving inpatient Medicaid IMD services over age 65
- Medicare Dual Eligibles
- Individuals Receiving Inpatient Medicaid IMD Services
- Reside in Nursing Facility or ICF/MR
- Children in Protective Foster Care
- Individuals Residing Outside of the Service Region

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
SSI and QMB Plus

Medicare Dual Eligibles Excluded:
SLMB Plus
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DFPS
- DSHS
- Local School Districts
- Mental Health Agency
- Protective and Regulatory Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions

ADDITIONAL INFORMATION

Individuals on SSI and QMB plus are the only Medicare dual eligibles that are eligibled to enroll. The program is mostly fee-for-service but on occasions there are some risk based arrangement.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Consumer Self-Report Data:
-Modified MHSIP survey

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries
-Use of unique NorthSTAR ID # (which includes Medicaid # for the Medicaid enrollees) for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

PIHP conducts data accuracy check(s) on specified data elements:
- -Date of Service
- -Date of Processing
- -Date of Payment
- -Provider ID
- -Type of Service
- -Medicaid Eligibility
- -Plan Enrollment
- -Diagnosis Codes
- -Procedure Codes
- -Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- -Depression management/care
- -Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
- -Patient satisfaction with care

Access/Availability of Care:
- -Average distance to mental health provider
- -Number and types of providers
- -Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
- -Drug Utilization
- -Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- -Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
- -Actual reserves held by plan
- -Days in unpaid claims/claims outstanding
- -Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- -Medical loss ratio
- -Net income
- -Net worth
- -State minimum reserve requirements
- -Total revenue

Health Plan/ Provider Characteristics:
- -Behavioral Health Specialty Network
- -Languages Spoken (other than English)
- -Provider turnover

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:

-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Coordination of primary and behavioral health care

Non-Clinical Topics:

None

Standards/Accreditation

PIHP Standards:
- -CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
- -NCQA Standards for Treatment Records

Accreditation Required for Participation:
None

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NorthSTAR

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-QIO-like entity

EQRO Name:
-Institute for Child Health Policy (ICHP)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

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CONTACT INFORMATION

State Medicaid Contact:	Pam Coleman Texas Health and Human Services Commission (512) 491-1302
State Website Address:	http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
TAA/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 01, 1993

Implementation Date:
August 01, 1993

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants

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Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Obstetricians/Gynecologists
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency

groups

-Public Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Texas
Community Health Choice
First Care
Superior Health Plan
Texas Health Network (STAR)
Community First
El Paso First Premier
Parkland Community Health Plan
Texas Children's Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
 Adult Medicaid AFDC Questionnaire
 Adult Medicaid SSI Questionnaire
 Child Medicaid AFDC Questionnaire
 Child Medicaid SSI Questionnaire

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-Behavioral health layout

Validation - Methods:

-Automated analysis of encounter data submission to help

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:

-Days in unpaid claims/claims outstanding

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization:

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:

-Languages Spoken (other than English)

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue
-Provider turnover

Beneficiary Characteristics:

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Clinical Topics:

-Adolescent Well Care/EPSDT
-Childhood Immunization
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Standards/Accreditation

MCO Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:

None

EQRO Organization:

-QIO-like entity

Accreditation Required for Participation:

None

EQRO Name:

-Institute for Child Health Policy, University of Florida

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities:

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Conduct performance improvement projects
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data
-Validation of performance improvement projects

Pay for Performance (P4P)

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Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
None

Population Categories Included:
None

Rewards Model:
None

Clinical Conditions:
None

Measurement of Improved Performance:
None

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Does not perform any of the Quality Activities for the PCCM Program

Consumer Self-Report Data:
None

Use of Collected Data:
None

UTAH
Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact:

Gail Rapp
Utah State Health Department
(801) 538-6358

State Website Address:

http://health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 23, 1982

Implementation Date:
July 01, 1982

Waiver Expiration Date:
December 31, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Skilled Nursing Facility, Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

UTAH
Choice Of Health Care Delivery

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Pregnant Women
-Medically Needy Children and Adults
-Special Needs Children (State defined)
-Medicare Dual Eligibies

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)
-During Retroactive Eligibility Period
-If Approved as Exempt from Mandatory Enrollment
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Individuals age 19 and older who quality for Medicaid by paying a spenddown and who are not aged or disabled
-Individuals residing in the Utah State Hospital of the Utah Developmental Center
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Have an eligibility period that is only retroactive
-Section 1931 non-pregnant adults age 19 and older and related poverty level populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Individuals who qualify for Medicaid by paying a spenddown and are aged or disabled
-Special Needs Children (State defined)
-Pregnant Women
-Individuals who qualify for Medicaid by paying a spenddown and are under age 19
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Use fee-for-service claims to identify members who received a carve-out service such as Early Interv
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U
Molina Healthcare of Utah (Molina)
IHC Health Plans Inc.

ADDITIONAL INFORMATION

For Medical-only PIHP-Included Services: Skilled Nursing Facility is provided for no more than 30 days. Child with special health care needs means a child under age 21 who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and required health and related services of a type or amount beyond that required by children generally, including a child who (1) is blind or disabled; (2) is in foster care or other out-of-home placement ; (3) is receiving foster care or adoption assistance; or (4) is receiving services that receives grant funds described in setion 501(a)(1)(D) of Title V. Non-risk arrangement. A Child with Special Health Care Needs means a child under 21 years of age who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932 (a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1936(u)-2)a_(2_(A): (1) is blind or disabled; (2) is in foster care or other out-of-home placement; (3) is receiving foster care or adoption assistance or (4) is receiving services through a family-centered, community-based coordinated care system that receives title V grant funds.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid

Adult with Special Needs Questionnaire
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

PIHP conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Place of Service
-Possible Duplicate Encounter

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across PIHPs

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of adults 50 and older who received an influenza vaccine
-Percentage of low birth weight infants

UTAH

Choice Of Health Care Delivery

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Health Plan Stability/ Financial/Cost of Care:

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Total revenue

Beneficiary Characteristics:

None

Use of Services/Utilization:

-Emergency room visits/1,000 beneficiary

Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Clinical practice guidelines
-Diabetes management
-Hypertension management
-Patient safety
-Post-natal Care
-Pre-natal care
-Sexually transmitted disease screening
-Well Child Care/EPSDT

Non-Clinical Topics:

-Appeals and grievances
-Coordination of care between physical and mental health plans
-Culturally/linguistically appropriate health care services
-Customer service
-HIPAA improvement
-Member satisfaction
-Provider relations/contracting improvement
-Provider satisfaction
-Reingeering of utilization & case management programs

Standards/Accreditation

PIHP Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:

-American Accreditation Healthcare Commission
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

Accreditation Required for Participation:

None

EQRO Name:

-Health Services Advisory Group, Inc.
-Utah Department of Health's Office of Health Care Statistics

UTAH
Choice Of Health Care Delivery

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult with Special Needs Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

UTAH

Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:	Don Hawley Utah State Department of Health (801) 538-6483
State Website Address:	http://health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 19, 2000

Implementation Date:
July 01, 2001

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Pregnant Women
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles

-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital or in the State Developmental Center
-Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards

Use of Collected Data:
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

UTAH

Non-Emergency Transportation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
None

PAHP conducts data accuracy check(s) on specified data elements:
None

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

State conducts general data completeness assessments:
No

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

UTAH
Prepaid Mental Health Program

CONTACT INFORMATION

State Medicaid Contact:

Karen Ford
Utah State Health Department
(801) 538-6637

State Website Address:

http://www.health.state.ut.us/Medicaid

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
July 01, 1991

Implementation Date:
July 01, 1991

Waiver Expiration Date:
December 31, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Transportation

Contractor Types:
-CMHC Operated Entity (Public)
-County Operated Entity (Public)
-CMHC - some private, some governmental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Pregnant Women
- -Foster Care Children
- -Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Resident of the State Developmental Center (DD/MR facility)
-Resident of the Utah State Hospital (IMD)
-Outpatient services for foster children
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Use fee-for-service claims data to identify clients received Early Intervention services
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Maternal and Child Health Agency
-Public Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
Davis Mental Health
Northeastern Counseling Center
Valley Mental Health
Weber Mental Health
Central Utah Mental
Four Corners Mental Health
Southwest Mental Health
Wasatch Mental Health

ADDITIONAL INFORMATION

Community Mental Health Centers serve as Prepaid Mental Health Plans to provide/coordinate all mental health services in 9 of Utahs 10 mental health service areas. Foster Care Children receive inpatient services only.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Consumer Self-Report Data:
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

State conducts general data completeness assessments:
Yes

Performance Measures

UTAH
Prepaid Mental Health Program

Process Quality:
-Continuity of Care
-Symptom reduction

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Racidivism
-Symptom reduction

Access/Availability of Care:
-Average time for intake
-Use of Services/Utlization

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net worth
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Coordination of primary and behavioral health care

Non-Clinical Topics:
-Accuracy and completeness of data for performance measures
-Timely access to treatment and tracking

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group, Inc.

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

VIRGINIA
MEDALLION/Medallion II

CONTACT INFORMATION

State Medicaid Contact:

Mary Mitchell
Department of Medical Assistance Services
(804) 786-3594

State Website Address:

http://www.dmas.virginia.gov/

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
MAXIMUS, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 2005

Implementation Date:
April 01, 2005

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

Enrollment

VIRGINIA
MEDALLION/Medallion II

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Refugees
-Spenddown
-Hospice
-Other Insurance
-Foster Care
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Subsidized Adoption

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

VIRGINIA
MEDALLION/Medallion II

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Hospice
-Refugees
-Spend-down
-Foster Care
-Subsidized Adoption

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Initial Interviews with new Medallion II enrollees
-Review claims activity of all new enrollees for special indicators
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP Virginia, Inc.
Healthkeepers, Inc.
Optima Family Care
Priority Health Care, Inc.
CareNet
MEDALLION
Peninsula Health Care, Inc.
Virginia Premier

ADDITIONAL INFORMATION

Medallion and Medallion II programs were combined on March 14, 2005. Title XXI SCHIP children are 6-19 years of age within 100%-133% FPGs. MPRO will become the EQRO effective July 1, 2006.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
 Adult Medicaid AFDC Questionnaire
 Child Medicaid AFDC Questionnaire
 Child with Special Needs Questionnaire

Use of Collected Data:
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national

data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes medication management
-Frequency of on-going prenatal care
-Heart Attack care
-Heart Failure care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
None

VIRGINIA
MEDALLION/Medallion II

Health Plan Stability/ Financial/Cost of Care:
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
None

Clinical Topics:
-Childhood Immunization
-Well Child Care/EPSDT

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-URAC (previously known as Utilization Review Accreditation Committee) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Delmarva Foundation for Medical Care, Inc.

EQRO Mandatory Activities:
-Annual Independent Evaluation
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

VIRGINIA
MEDALLION/Medallion II

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
    Child with Special Needs Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Performance Measures

Process Quality:
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of

Access/Availability of Care:
-Children's access to primary care practitioners

Provider Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization:
None

Beneficiary Characteristics:
None

VIRGINIA

Virginia Non-Emergency Transportation Services

CONTACT INFORMATION

State Medicaid Contact:

Jeff Nelson
DMAS
(804) 371-8857

State Website Address:

www.dmas.virginia.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
August 23, 2005

Implementation Date:
September 01, 2005

Waiver Expiration Date:
August 31, 2007

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program

Medicare Dual Eligibles Included:
None

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare Solutions

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-Network Data
-On-Site Reviews
-PAHP Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-Satisfaction Survey

Use of Collected Data:
-Plan Reimbursement

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Abandonment rate
-Average Talk Time
-Average Time to Answer
-Average Wait to Abandon
-Call Center volume
-Calls Answered
-Stretcher Van Trips
-Trips Scheduled

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Access to Transportation Services

Use of Services/Utilization:
-Transportation Utilization

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Driver and Provider Credentialing

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-Individual PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
None

Non-Clinical Topics:
-Satisfaction Survey

Standards/Accreditation

VIRGINIA

Virginia Non-Emergency Transportation Services

PAHP Standards:
-none

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

WASHINGTON

Disease Management Program

CONTACT INFORMATION

State Medicaid Contact:	Alice Lind Health and Recovery Services Administration/Dept. of Social an (360)725-1629
State Website Address:	http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 10, 2003

Implementation Date:
April 01, 2002

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-SSI eligible beneficiaries having one or more of the following: Asthma, Diabetes, Heart Failure, COP
-TANF beneficiaries with Asthma

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

WASHINGTON
Disease Management Program

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Claims data
-Self-reporting via initial assessment

Agencies with which Medicaid Coordinates the Operation of the Program:
-Social Services Agencies
-State Department of Health

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson Health Solutions LLC

ADDITIONAL INFORMATION

The State contracts with McKesson and Renaissance to provide enrollment, assessment and education and targets beneficiaries with one or more of the following diseases: Asthma, Diabetes, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), End Stage Renal Disease (ESRD) and Chronic Kidney Disease. As part of their program, McKesson provides a face-to-face program component with high risk enrollees to ensure they receive necessary services.

The program was terminated as of July 1, 2006.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Enrollee Hotlines
-Performance Measures (see below for details)
-Self Reported Health Outcomes

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality:
-Asthma care - medication use
-Diabetes management/care

Health Status/Outcomes Quality:
-Clinical Indicators
-Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

WASHINGTON

Hospital Selective Contract Waiver

CONTACT INFORMATION

State Medicaid Contact:

Leslie Lynam
DSHS/HRSA/DBF/Rates
(360) 725-1823

State Website Address:

http://maa.dshs.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 01, 1988

Implementation Date:
June 02, 1988

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

Washington hospitals in the Hospital Selective Contract Waiver program receive a negotiated rate of payment for services provided to medicaid clients for inpatient hospital stays. The payment rate is lower than what they would otherwise receive were it not for the 1915(b)(4) Hospital Selective Waiver program.

WASHINGTON

The Integrated Mental Health Services

CONTACT INFORMATION

State Medicaid Contact:

Judy Gosney
Mental Health Divison
(360) 902-0827

State Website Address:

http://www1.dshs.wa.gov/mentalhealth

PROGRAM DATA

Program Service Area:
County
Region

Initial Waiver Approval Date:
April 27, 1993

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
July 01, 1993

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Waiver Expiration Date:
March 31, 2008

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, EPSDT, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Rehabilitation Case Management

Allowable PCPs:
-Service Providers Under This Waiver Do Not Meet PCP Definition

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Reside in Nursing Facility or ICR/MR
-Other Insurance

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Residents of State-owned institutions
-Pregnant Women included in Family Planning Waiver
-Homeless People not Enrolled in Medicaid

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

No

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All Persons Meet SCHN

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Employment Agency
-Housing Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Regional Support Network

ADDITIONAL INFORMATION

WASHINGTON
The Integrated Mental Health Services

Due to the nature of the waiver which is for a limited segment of services, the program does designate a primary care provider. Individuals choose their own providers. Pregnant women in the Basic Health program (state funded program) are excluded from the Mental Health program.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Measures (see below for details)
-PIHP Standards
-Quality Review Team

Consumer Self-Report Data:

-Consumer/Beneficiary Focus Groups
-MHSIP Child, Family, and Adult Survey

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

PIHP conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Our data is rolled up from the providers to the entity to the MHD
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:

Yes

WASHINGTON
The Integrated Mental Health Services

Performance Measures

Process Quality:
-Follow-up after hospitalization for mental illness
-level of functioning at treatment intervals
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Access to Appointment
-Availability of MHPs
-Average Distance to Service
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Crisis Contacts
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Outpatient Mental Health Hours

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race

Standards/Accreditation

PIHP Standards:
-16 state pilot indicator project
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-APS Healthcare Inc.

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Validation of encounter data

WEST VIRGINIA
Mountain Health Trust

CONTACT INFORMATION

State Medicaid Contact:	Shelley Baston Office of Managed Care, Bureau for Medical Service (304)-558-5978
State Website Address:	http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Automated Health Systems, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 07, 2004

Implementation Date:
July 07, 2004

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Internists
-Federally Qualified Health Centers (FQHCs)

Enrollment

WEST VIRGINIA
Mountain Health Trust

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Medically Needy

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency

members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan
Physician Assured Access System
Health Plan of the Upper Ohio Valley
Unicare Health Plan of WV

ADDITIONAL INFORMATION

The State combined its Physician Assured Access System (PAAS) program with the Mountain Health Trust Program in July 2004. PAAS is available in all 55 counties. The reason for multiple enrollment for Section 1931 (AFDC/TANF) Adults and Children and related populations is because in counties with only one MCO, clients can choose to remain in the PCCM program on a voluntary basis. Foster Care Children can also voluntarily enroll in the PCCM program.. The MCOs do not operate in all counties. Beneficiaries are allowed to change plans once per month. If beneficiaries switch plans, it will become effective on the first day of the following month. Reason for multiple enrollment for Children and Related Populations and Adults and Related Populations: In counties with only one MCO, clients can choose to remain in the PCCM program in an Urban county.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Compliants, grieveances and disenrollment data
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-Disenrollment Survey
-State-developed Survey
-State-developed Survey of Children with Special Health Needs

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)

-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-MCO commercial utilization rates, comparisons to norms, comparisons to submitted bills or cost-ratios
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Days/1000 an average length of stay of IP administration, ER visits, ambulatory surgery, maternity care, newborn care
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary

-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue
-Total Third Party Liability Collections Made By Source

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
None

Clinical Topics:
-Coordination of care for persons with physical disabilities
-Post-natal Care

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Delmarva

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of

clinical or non-clinical services
-Sentinel Event Review
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
None

Use of Collected Data:
-Beneficiary Provider Selection

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Average distance to primary care case manager
-Percent of PCPs with open or closed patient assignment panels

Provider Characteristics:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race

Section:
1115(a) - Demonstration Waiver Programs

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ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

State Medicaid Contact:

Tom Betlach
AHCCCS
(602) 417-4483

State Website Address:

http://www.AZAHCCCS.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 13, 1982

Implementation Date:
October 01, 1982

Waiver Expiration Date:
September 30, 2011

Sections of Title XIX Waived:
-1902(a)(10)((a)(ii)(V) - Eligibility based on Institutionalized Status
-1902(a)(10)(B) - Amount, Duration & Scope
-1902(a)(10)(B)(i) - MCO Enrollees
-1902(a)(13) except 1902(a)(13)(A) - DSH Requirements
-1902(a)(14) - Cost Sharings
-1902(a)(18) - Estate Recovery
-1902(a)(23) - Freedom of Choice
-1902(a)(34) - Retroactive Coverage
-1902(a)(4) - Proper & Efficient Administration
-1902(a)(54) - Drug Rebate

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A) except 1903(m)(2)(A)(i), 1903(m)(2)(A)(vi), 1903(m)(2)(A)(xii), 1903(m)(2)(H)
-Expenditures Related to Benefits
-Expenditures Related to Existing Eligibility Groups based on Eligibility Simplification

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental

Allowable PCPs:
-Physician Assistants
-Certified Nurse Midwives
-Pediatricians
-General Practitioners
-Family Practitioners

Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppresant Drugs, Transportation, Vision, X-Ray

-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
QMB
SLMB
QI 1

Populations Mandatorily Enrolled:
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Adults Without Minor Children Title XIX Waivers
-Adoption Subsidy Children
-Title XIX Waiver Spend Down Population
-HIFA Parents
-Foster Care Children
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
QI and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Crisis, Detoxification, Emergency and Non-emergency Transportation, IMD, Individual Therapy and Counseling, Inpatient Mental Health, Inpatient Psychiatric, Inpatient Substance Use Disorders, Laboratory, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Pharmacy, Residential Substance Use Disorders Treatment Programs, X-Ray

Allowable PCPs:
-PCP is in Medicaid Health Plan

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
QMB
SLMB

Populations Mandatorily Enrolled:
-Foster Care Children
-Families with Dependent Children under age 18 (1931) and Continuing Coverage (TMA/CS)
-Pregnant Women (SOBRA)
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Adults Without Minor Children Title XIX Waiver
-Adoption Subsidy Children
-Section 1931 Families with Children and Related Populations
-Title XIX Waiver Spend Down
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QI and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Maternal and Child Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AZ Physicians IPA (Family Planning Extension)
Care 1st Health Plan
Cochise Health Systems (PC)
Department of Economic Security/Childrens Medical and Dental Program (HP)
Department of Health Services (Behavioral Health)
Health Choice Arizona (Family Planning Extension)
Maricopa Health Plan (Family Planning Extension)
Mercy Care Plan (Family Planning Extension)
Mercy Care Plan (PC)
Phoenix Health Plan/Community Connection (HP)
Pima Health System (HP)
Pinal County Long Term Care (PC)
University Family Care (HP)
AZ Physicians IPA (HP)
Care 1st Health Plan (Family Planning Extension)
Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension)
Department of Economic Security/Division of Developmental Disabilities (PC)
Evercare Select (PC)
Health Choice Arizona (HP)
Maricopa Health Plan (HP)
Mercy Care Plan (HP)
Phoenix Health Plan/Community Connection (Family Planning Extension)
Pima Health System (Family Planning Extension)
Pima Health System (PC)
University Family Care (Family Planning Extension)
Yavapai County Long Term Care (PC)

ADDITIONAL INFORMATION

A managed care system based on prepaid capitation to health plans and long term program contractors. Arizona contracts with the Arizona Department of Health Services, who in turn contracts with Regional Behavioral Health Authorities (RBHAs) to provide behavioral health services to AHCCCS members.

Hospice, vision and hearing services are only available for EPSDT. Case management service is only available for Division of Development Disabilities.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Dentist Survey
-Encounter Data (see below for details)
-Enrollee Hotlines
-EPSDT Annual Reports
-EPSDT Quarterly Reports
-Family Planning Annual Reports
-Focused Studies
-Maternity Annual Reports
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-Provider Data
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NCPDP, ASC X12 837)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent well-care visit rates
-Adults Access to Preventitive/Ambulatory Health Services
-Alzheimers study to evaluate appropriateness of care
-Annual Dental Visits among Children (ages 3 - 20)
-Asthma - appropriate use of medications

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of low birth weight infants

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

-Blood Lead Screening
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children's Access to Primary Care Providers
-Children's Access to Primary Care Providers - KidsCare Population
-Chlamydia screening
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Health Screenings
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Influenza Immunizations and Pneumococcal Vaccination Rates in the Elderly and Physically Disabled
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Low Birth Weight Deliveries
-Patient Satisfaction with Care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Population in Nursing Facilities and In Home Community Based Setting (ALTCS indicator)
-Prenatal Care in the First Trimester
-Utilization of Family Planning Services (Internal Report Only)
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Alzheimer study to evaluate appropriateness of HCBS care
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries
-Utilization of Family Planning Services (Internal Report Only)
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)
-Net income
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:

-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Use of Services/Utilization:

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:

-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Medical problems of the frail elderly

-Pharmacy management
-Prevention of Influenza
-Timeliness of Initiation of Services

Non-Clinical Topics:
-Advance Directives
-Availability of language interpretation services
-Provider education regarding cultural health care needs of members

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Health Services Advisory Group
-Healthcare Excel
-Mercer
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Ad hoc QM reviews
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Population Categories Included:
None

Clinical Conditions:
None

Initial Year of Reward:
2007

Program Payers:
Nursing Homes through Altcs contractors being initiated

Rewards Model:
None

Measurement of Improved Performance:
None

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

QUALITY ACTIVITIES FOR PIHP

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Dentist Survey
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-PIHP Standards
-Provider Data
-Quality Improvement Projects (QIPS)
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-Member Survey
-State-developed Survey

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

PIHP conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

State conducts general data completeness assessments:

Yes

-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:

-Appropriateness of services
-Coordination of care with acute contractors/pcp's
-Cultural competency
-Informed consent for psychotropic medication prescription
-Member/Family involvement
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Sufficiency of assessments

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Symptomatic and functional improvement
-Transition of Care

Access/Availability of Care:

-Access to care/ appointment availability
-Appointment Standards
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:

-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:

-Languages Spoken (other than English)

Beneficiary Characteristics:

-Geographic
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PIHPs
-PIHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:

-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Behavior health assessment - birth to 5 years of age
-Coordination of primary and behavioral health care
-Follow-up after hospitalization
-Informed consent for psychotropic medication prescription
-Pharmacy management
-Reducing the use of seclusion & restraint
-Transition of Care

Non-Clinical Topics:

-Availability of language interpretation services

-Provider education regarding cultural health care needs of members

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Health Services Advisory Group
-Mercer and Health Care Excel

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

CALIFORNIA
Senior Care Action Network

CONTACT INFORMATION

State Medicaid Contact:

Della Cabrera
Office of Long Term Care
(916) 440-7532

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 07, 1985

Implementation Date:
January 01, 1985

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(e)(2)(A)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Not Applicable

SERVICE DELIVERY

Social HMO - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Care, Health Education, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Mental Health, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Internists
-Nurse Practitioners
-Physician Assistants
-General Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Aged and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Special Needs Children (BBA Defined)
-Medicare Dual Eligibles
-Special Needs Children (State Defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for anorexia, weight loss, weight gain
-Agents when used to promote fertility
-Agents when used for cosmetic purposes or hair growth
-Agents when used for symptomatic relief of cough and colds
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Nonprescription drugs
-Barbituates
-Drugs used to promote fertility

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Senior Care Action Network (SCAN)

ADDITIONAL INFORMATION

SCAN eligibility requires the beneficiary to be dually eligible, over 65 years of age and older and for long term care benefits must meet the criteria for skilled or intermediate nursing care. SCAN is the only social HMO in California.

This program provides medical, social and limited long term care services.

DELAWARE
Delaware Physicians Care , Inc.

CONTACT INFORMATION

State Medicaid Contact:

Kay Holmes
Delaware Social Services
(302) 255-9529

State Website Address:

www.dmap.state.de.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS, Inc

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 17, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
- -1902(a)(10)
- -1902(a)(10)(B) Comparability of Services
- -1902(a)(13)(E)
- -1902(a)(23) Freedom of Choice
- -1902(a)(30)(A)
- -1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
- -Eligibility Expansion
- -Family Planning
- -Inst. For Mental Disease

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Integrated Services, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Private Duty Nursing, Skilled Nursing Facility, Speech Therapy, Vision and hearing, X-Ray

Allowable PCPs:
- -Pediatricians
- -General Practitioners
- -Family Practitioners
- -Internists
- -Obstetricans/Gynecologists or Gynecologists
- -Federally Qualified Health Centers (FQHCs)
- -Rural Health Clinics (RHCs)
- -Nurse Practitioners
- -Nurse Midwives
- -Psychiatrists
- -Psychologists
- -Clinical Social Workers
- -Addictionologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Special Needs Children (State defined)
-Poverty-Level Pregnant Women
-Special Needs Children (BBA defined)
-Adults, nonhead of household at or below 100% FPL
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Tricare/CHAMPUS

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency

DELAWARE

Delaware Physicians Care , Inc.

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delaware Physicians Care, Inc

ADDITIONAL INFORMATION

Special Needs Children (State-defined): All children below 21, no income or resource limit that meet the SSN Functional Disability Requirements. Vision and hearing services are provided to children under 21.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCO

electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Blood tests results for diabetes
-Obesity rates for adolescents
-Patient satisfaction with care
-Percentage of low birth weight infants
-Provider surveys

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of PCP visits per beneficiary
-Number of readmits within a 10 day period

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Pharmacy management
-Pre-natal care

Non-Clinical Topics:

-Availability of language interpretation services
-Health information technology (e.g. state implementation of

immunization and other registries, telemedicine initiatives, etc...)
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Mercer, Inc.

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Clinical Conditions:
Depression
Prenatal Care

Initial Year of Reward:
2004

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Assessing the adoption of systematic quality improvement processes

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

DELAWARE
Diamond State Partners

CONTACT INFORMATION

State Medicaid Contact:	Kay Holmes Delaware Medicaid (302)255-9529
State Website Address:	www.dmap.state.de.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS, Inc

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 17, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(a)(24)
-1902(a)(30)(A)
-1902(m)(2)(A)(ii)(vi)
-1903(f)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion
-Family Planning
-Inst. For Mental Disease

SERVICE DELIVERY

Fee for Service Model - Fee-for-Service

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Private Duty Nursing, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Psychiatrists
-Psychologists
-Clinical Social Workers

-Addictionologists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Expanded Adults at or below 100 % FPL
-Special Needs Children (BBA defined)
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-CHAMPUS

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Diamond State Partners

ADDITIONAL INFORMATION

None

HAWAII
Hawaii QUEST

CONTACT INFORMATION

State Medicaid Contact:

Wesley Mun
Hawaii Department of Human Services, Med-QUEST Div
(808) 692-8050

State Website Address:

http://www.state.hi.us/dhs/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility months guaranteed eligibility

Initial Waiver Approval Date:
July 16, 1993

Implementation Date:
September 01, 1993

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:
-1902(a)(10)(A)(i)(I),(III),(IV),(VII)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(14) Cost Sharing
-1902(a)(17) Comparability of Eligibility
-1902(a)(17)(D)
-1902(a)(18)
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1902(a)(4)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi)
-1932(a)(4)(A)
-MCO Definition 1903(m)(1)(A)
-MCO Definition 1903(m)(2)(A)(i)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Cornea and Kidney Transplants and Bone Grafts, Dental, Dietary Services, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Intermediate Care Facility, Laboratory, Language/Interpreter Services, Maternity Services, Occupational Therapy,

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)

Optometry, Certified Nurse Midwife, Nurse Practitioner & Physician Assistant Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Preventive Services, Skilled Nursing Facility, Speech Therapy, Sterilization/Hysterectomies, Subacute Care (when cost appropriate), Transportation, X-Ray

-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Detoxification, IMD Services, Inpatient Mental Health Services, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders Services, Pharmacy, Residential Substance Use Disorders Treatment Programs

Allowable PCPs:
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency

HAWAII

Hawaii QUEST

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aloha Care

Child & Adolescent Mental Health Division, Department of Health

Early Intervention Programs, Department of Health

HMSA-Behavior Health for SMI

HMSA-Medical

Kaiser Permanente

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO

data between trading partners, such as hospitals, long term care facilities,

commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

HAWAII
Hawaii QUEST

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Asthma management
-Diabetes management

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Private accreditation organization

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Asthma
Childhood immunizations
Diabetes
Prenatal Care
Well-child visits

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2007

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:
-Follow-up after hospitalization for mental illness

Access/Availability of Care:
-Average wait time for an appointment with PCP

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics:

Not Applicable - PIHPs are not required to conduct common project(s)

Clinical Topics:

None

Standards/Accreditation

PIHP Standards:
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Private accreditation organization

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Health Services Advisory Group

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

KENTUCKY
Kentucky Health Care Partnership Program

CONTACT INFORMATION

State Medicaid Contact:	Debbie Salleng Kentucky Department for Medicaid Services (502) 564-8196
State Website Address:	http://chs.state.ky.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 06, 1995

Implementation Date:
November 01, 1997

Waiver Expiration Date:
October 31, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(15) Payment for FQHCs
-1902(a)(17) Financial Eligibility Standard
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive eligibility
-1902(e)(2) Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Expenditures for capitation payments made to a MCO not in compliance with section 1903(2)(A)(xi)
-Expenditures for payment to MCOs that restrict disenrollment rights

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

KENTUCKY

Kentucky Health Care Partnership Program

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Residents of Institutions for Mental Disease
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Psychiatric Residential Treatment Facility PRTF
-Eligibility for Spend down

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-TITLE XXI SCHIP

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-None - managed care entity provides standard prescription drug coverage

Provides Part D Benefits:
Yes

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Uses claims data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-KY Commission for Children with Special Health Care Needs
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

KENTUCKY

Kentucky Health Care Partnership Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data:

None

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

Collection: Standardized Forms:

None

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Comparison to claims payment data
-Per member per month analysis and comparisons across

MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Diabetes management
-Hypertension management
-Inpatient maternity care and discharge planning
-Low birth-weight baby
-Post-natal Care
-Pre-natal care
-Sickle cell anemia management

-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-QIO-like Entity

Accreditation Required for Participation:
-Plan required to obtain MCO accreditation by NCQA or other accrediting body

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of high cost services and procedures
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as clams and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

MARYLAND
HealthChoice

CONTACT INFORMATION

State Medicaid Contact:

Tricia Roddy
Department of Health and Mental Hygiene
(410) 767-5809

State Website Address:

http://www.dhmh.state.md.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
(PSI) Policy Studies, Inc

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
June 02, 1997

Waiver Expiration Date:
May 31, 2008

Sections of Title XIX Waived:
- -1902(a)(10)
- -1902(a)(10)(B) Comparability of Services
- -1902(a)(13)(E)
- -1902(a)(23) Freedom of Choice
- -1902(a)(34)
- -1902(a)(4)(A)
- -1902(a)(47)
- -1902(a)(5)
- -1902(b)
- -1903(u)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
- -1902(a)(43)
- -1903(m)(2)(A)(i)
- -1903(m)(2)(A)(vi) Guaranteed Eligibility, IMD
- -Family Planning

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Diabetes Care, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
- -Pediatricians
- -General Practitioners
- -Family Practitioners
- -Internists
- -Obstetricians/Gynecologists
- -Federally Qualified Health Centers (FQHCs)
- -Rural Health Clinics (RHCs)

-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Institutionalized more than 30 days
-If enrolled in Model Waiver for Fragile Children
-If determined Medically Needy Under a Spend Down
-A child in an out-of-State placement
-Inmates of public institutions
-Enrolled in Family Planning Waiver Program
-Pharmacy Assistance Recipients
-Aliens

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Pregnant Women
-Home and Community Based Waivers
-SSI Recipients
-Refugees
-TITLE XXI SCHIP

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

groups
-Uses provider referrals to identify members of these groups

-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP Maryland Inc.
Helix Family Choice
Maryland Physicians Care
United Health Care

Coventry Diamond Plan
JAI Medical System
Priority Partners MCO

ADDITIONAL INFORMATION

An eligible HealthChoice enrollee may be permitted to disenroll "for cause" from an MCO and enroll in another MCO outside of his/her annual right to change period if he/she is not hospitalized. Dental services provided for enrollees under 21 years old and pregnant women of any age. The Department and not the MCOs are responsible for purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers. There are additional optional services that some MCOs provide for their enrollees such as dental services for adults. Pregnant women in the Maryland Childrens Health Program are guaranteed eligibility for the duration of the pregnancy and 2 months postpartum.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Report Card

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
    Child with Special Needs Questionnaire

Use of Collected Data:

-Beneficiary Plan Selection
-Consumer Report Card
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rate
-Ambulatory Care for SSI Children and Adults
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-HEDIS-Prenatal and Postpartum Care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Call Abandonment
-Call Answer Timeliness
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Use of Services/Utilization:

-Births and average length of stay, newborns
-Discharge and average length of stay-materninity care
-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics:

None

-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
None

Clinical Topics:
-Chronic Kidney Disease
-Pre-natal care

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Delmarva Foundation for Medical Care, Inc.

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of selected performance measures

EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Clinical Conditions:
Ambulatory Care for SSI recipients
Cervical Cancer Screening
Childhood immunizations
Dental Services
Diabetes
Lead Screening
Prenatal Care
Well-child visits

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2002

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

MASSACHUSETTS

Mass Health

CONTACT INFORMATION

State Medicaid Contact:

Robin Callahan
Executive Office of Health and Human Services
(617) 573-1745

State Website Address:

http://www.mass.gov/masshealth

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 24, 1995

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:

-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)(I)-(III)
-1902(a)(13)
-1902(a)(14)
-1902(a)(16)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(27)
-1902(a)(3)
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)(A)
-1902(a)(43)
-1902(a)(57)
-1902(a)(58)
-1902(a)(8)

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(m)(2)(H) Automatic Reenrollment
-Diversionary Services
-Eligibility Expansion
-Expenditures disallowed under 1903(u)
-Expenditures from the Safety Net Care Pool
-Inst. For Mental Disease
-Insurance Reimbursement
-Medicaid Eligibility Quality Control
-Prenatal Services to presumptive eligibles
-Special Programs

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Federally Qualified Health Centers (FQHCs)
-Other Specialists Approved on a Case-by-Case Basis
-Hospital Outpatient Departments
-Rural Health Clinics (RHCs)
-General Practitioners
-Family Practitioners
-CHCs
-HLHCs

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-TITLE XXI SCHIP
-Foster Care Children
-Blind/Disabled Children and Related Populations
-Special Needs Children (BBA defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

MASSACHUSETTS
Mass Health

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Detoxification, Diversionary Services, Emergency Services Programs, Inpatient Mental Health, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders Services, Residential Substance Use Disorders Treatment Programs, Screening, Identification, and Brief Intervention

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Over 65

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, Dental/Maxillofacial Only, Dialysis, Durable Medical Equipment, Early Intervention, EPSDT, ESP services, Family Planning, Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Orthotics, Prosthetics, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatry, Skilled Nursing Facilty, Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Other Specialists Approved on a Case-by-Case Basis
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Pediatricians
-Physician Assistants
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

MASSACHUSETTS

Mass Health

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan
MA Behavioral Health Partnership
Network Health
Fallon Community Health Plan
Neighborhood Health Plan
Primary Care Clinician Plan

ADDITIONAL INFORMATION

Mass Health has a behavioral carve-out for PCCM enrollees and for children in the care or custody of the Commonwealth. Regarding the MH/SUD PIHP included services, there is no long-term care in mental health residential or residential substance abuse treatment programs. The Outpatient Day programs are defined as full or part-time substance abuse or mental health services provided in an ambulatory setting. Some MCO Program services have age limitations. Under the MCO, Skilled Nuresing Facility services are provided for up to 100 days. State is currently in EQRO negotiations. Emergency Transportation is provided. Chiropractic services are available for beneficiaries under 21. Vision services are available for medical reasons only.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHMI
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire
-PHDS Survey

Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national

data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Appropriate testing for children with URI
-Asthma care - medication use
-Breast Cancer screening rate
-Check-ups after delivery
-Controlling high blood pressure
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Use of Services/Utilization:

-Average LOS
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at

MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Audited Financial Statements
-Cost/Utilization
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Outlier Spending
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Coordination of care for persons with physical disabilities
-Coordination of primary and behavioral health care
-Depression management
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-QIO-like entity

Accreditation Required for Participation:
None

EQRO Name:
-APS Healthcare

EQRO Mandatory Activities:
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Clinical Conditions:
Childhood immunizations

Initial Year of Reward:
Not Applicable

Program Payers:
Medicaid has collaborated with a public sector entity to support the P4P program

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Consumer Self-Report Data:
-Consumer Satisfaction Surveys
-Consumer/Beneficiary Focus Groups

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-State Managed Care Medicaid Quality Strategy
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help

health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Continuing Care Rate
-Depression management/care
-Follow-up after hospitalization for mental illness
-Initiation and engagement of SUD treatment
-Med Monitoring Rates
-Re-admission Rates
-Service after a diversion from inpatient care

Health Status/Outcomes Quality:
-Clinical Outcomes Measurement Program
-Community Tenure Post Hospitalization
-Patient satisfaction with care

Access/Availability of Care:
-Adolescent Access
-Adult's access to preventive/ambulatory health services
-Children's Psychiatric Access Program
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Emergency Service Program Use/1000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Audited Financial Statement
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-IBNR Methodology
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover
-Type of Service Provided

MASSACHUSETTS
Mass Health

Beneficiary Characteristics:
-Age Categories
-DMH Affiliation
-DSS Affiliation
-Rating Categories

Performance Improvement Projects

Project Requirements:
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Coordination of primary and behavioral health care
-Depression management
-ETOH and other substance abuse screening and treatment

Non-Clinical Topics:
-Member Access to Behavioral Health Services

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-QIO-like entity

Accreditation Required for Participation:
None

EQRO Name:
-APS

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Assessment of PIHP Information System
-Calculation of performance measures
-Conduct of performance improvement projects

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Network Data
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

MASSACHUSETTS
Mass Health

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Controlling high blood pressure
-Depression medication management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels

Use of Services/Utilization:
-ALOS overall MH/SUD
-Average number of visits to MH/SUD providers per beneficiary
-Continuing Care rates/MH
-Discharge per 1000 MH/SUD
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Intensive Clinical Management/MH/SUD/1000
-Number of inpatient days MH/SUD
-Pregnancy-Enhanced Services MH/SUD/1000
-Re-admission rates of MH/SUD

Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries auto-assigned to PCP
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Coordination of primary and behavioral health care
-Depression management
-Diabetes management
-Emergency Room service utilization
-Inpatient maternity care and discharge planning
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

MINNESOTA

Minnesota Prepaid Medical Assistance Program-1115(a)

CONTACT INFORMATION

State Medicaid Contact:

Christine Bronson
Minnesota Department of Human Services
(651) 431-2914

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1985

Implementation Date:
July 01, 1985

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:

-1902(a)(1) Statewideness
-1902(a)(10)(A)(i)(IV) Coverage/Benefits for Pregnant Women
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(17) Comparability of Eligibility
-1902(a)(17)(D) Financial Responsibility/Deeming
-1902(a)(23) Freedom of Choice
-1902(a)(4)(A) MEQC
-1902(e)(5) and (6) Eligibility Procedures

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-Eligibility Expansion
-Medical Education

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, ICF/MR, Community-Based Services, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1115(a)

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Non-documented alien recipients who receive only emergency MA under Minn. Stat. 256B.06(4)
-Recipients with terminal or communicable diseases at time of enrollment
-Recipients with private coverage through a MCO not participating in Medicaid
-Refugee Assistance Program recipients
-Recipients residing in state institutions
-Non-institutionalized recipients eligible on spend down basis
-Blind and disabled recipients under age 65

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1115(a)

Health Partners
Medica
PrimeWest Health System
UCARE

First Plan Blue
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
-Disenrollment Survey
-State-developed Survey

Use of Collected Data:

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management/care
-Diabetes medication management
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child visit rates

Health Status/Outcomes Quality:
-CAHPS

Access/Availability of Care:
-Average distance to PCP

Use of Services/Utilization:
-Well-child visits in first 15 months of life

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adverse Events
-Breast cancer screening (Mammography)
-Cardiovascular Care
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Heart Failure Care
-Leapfrog Reporting
-Pneumonia Care
-Sexually transmitted disease screening
-Treatment of myocardial infraction
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-BBA Managed Care Standards
-CMS's PIP requirements

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Private accreditation organization
-QIO-like entity

Accreditation Required for Participation:
None

EQRO Name:
-MetaStar (QIO)
-Michigan PRO (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Cardiac Care
Diabetes

Initial Year of Reward:
1999

Program Payers:
MCOs

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

MINNESOTA

MinnesotaCare Program For Families And Children

CONTACT INFORMATION

State Medicaid Contact:	Christine Bronson Minnesota Department of Human Services (651) 431-2914
State Website Address:	http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
April 27, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A)(i)(IV) Coverage/Benefits for Pregnant Women
-1902(a)(10)(B) - Amount, Duration & Scope
-1902(a)(17)(D) - Financial Responsibility/Deeming
-1902(a)(23) Freedom of Choice
-1902(a)(4)(A) - MEQC
-1902(a)(4)(A) MEQC
-1902(e)(5) and (6) - Eligibility Procedures

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(u) MEQC
-Medical Education

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, ICF/MR, Home And Community Based Waiver, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

MINNESOTA
MinnesotaCare Program For Families And Children

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Pregnant Women Up to 275 of FPG With Other Insurance
-Enrolled in Another Managed Care Program
-Individuals with household income above 150% of poverty with other health insurance
-Individuals with health insurance available through employment if subsidized at 50% or greater

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Pregnant Women And Children Whose Income Is At Or Below 275% FPG
-Parents and other relative caretakers whose household income is below 275% of poverty.

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
PrimeWest Health System
UCARE

First Plan Blue
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

MINNESOTA
MinnesotaCare Program For Families And Children

ADDITIONAL INFORMATION

PCP provider types are designated by HMOs rather than State. Programs includes all MA benefits except nursing facilities.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility

State conducts general data completeness assessments:
No

- -Plan Enrollment
- -Diagnosis Codes
- -Procedure Codes

Performance Measures

Process Quality:

- -Adolescent immunization rate
- -Adolescent well-care visit rates
- -Cervical cancer screening rate
- -Cholesterol screening and management
- -Depression management
- -Diabetes management/care
- -Immunizations for two year olds
- -Influenza vaccination rate
- -Lead screening rate
- -Well-child care visit rates in first 15 months of life
- -Well-child visit rates

Health Status/Outcomes Quality:

- -CAHPS

Access/Availability of Care:

- -Average distance to PCP

Use of Services/Utilization:

- -Well-child care visit rates in first 15 months of life

Health Plan Stability/ Financial/Cost of Care:

- -Actual reserves held by plan
- -Medical loss ratio
- -Net income
- -State minimum reserve requirements
- -Total revenue

Health Plan/ Provider Characteristics:

None

Beneficiary Characteristics:

None

Performance Improvement Projects

Project Requirements:

- -MCOs are required to conduct a project(s) of their own choosing
- -Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

- -Adolescent Immunization
- -Adverse Events
- -Breast cancer screening (Mammography)
- -Cervical cancer screening (Pap Test)
- -Childhood Immunization
- -Coronary artery disease prevention
- -Diabetes management
- -Heart Failure Care
- -Leapfrog Reporting
- -Pneumonia Care
- -Treatment of myocardial infraction
- -Well Child Care/EPSDT

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:

- -BBA Managed Care Standards
- -CMS's PIP Standards
- -CMS's Quality Improvement System for Managed Care

Accreditation Required for Participation:

None

(QISMC) Standards for Medicaid and Medicare

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Private Accreditation Organization
-QIO-like entity

EQRO Name:
-MetaStar (QIO)
-Michigan PRO (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Cardiac Care
Diabetes

Initial Year of Reward:
2006

Program Payers:
MCOs

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

MISSOURI

MC+ Managed Care/1115

CONTACT INFORMATION

State Medicaid Contact:

Susan Eggen
Department of Social Services, Division of Medical Services
(573) 751-5178

State Website Address:

http://www.dss.mo.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 29, 1998

Implementation Date:
September 01, 1998

Waiver Expiration Date:
August 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(u) MEQC
-Eligibility Expansion
-Family Planning Eligibility Expansion
-Indigent/Clinic Expenditures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation - emergency only, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-PCP Teams
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-PCP Clinics - which can include FQHCs/RHCs

Enrollment

MISSOURI
MC+ Managed Care/1115

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Presumptive Eligibility for Children
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Data Match with Other State Agencies
-Health Risk Assessments
-Helpline
-MCOs monitor Drug Usage
-MCOs use ER Encounters
-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-Reviews grievances and appeals to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Other State Agencies as necessary
-Public Health Agency
-Social Security Administration

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of Kansas City, Blue Advantage+ Plus

Family Health Partners

HealthCare USA

Missouri Care

Community Care Plus

FirstGuard

Mercy Health Plans

ADDITIONAL INFORMATION

Only Emergency Transportation service is provided. Allowable PCPs: Health Plans can choose to designate OB/GYNs for PCPs. PCP clinics can include FQHCs/RHCs. Ombudsman service is only provided to the Eastern and Western Region only.

Any child indentified as having special health care needs, defined as a condition which, left untreated, would result in the death or serious physical injury of a child, and who does not have access to affordable employer-subsidized health care insurance, is exempt from the requirement to be without health care coverage for six months in order to be eligible for services. A child shall not be subject to the 30-day waiting period as long as the child meets all other qualifications for eligibility.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards
-Monitoring of MCO Standards
-Network Data
-Ombudsman - Eastern and Western regions only
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
Child Medicaid AFDC Questionnaire

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-See Attachment 1 for additional Data Accuracy Checks

State conducts general data completeness assessments:

No

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Chlamdyia screening in women
-C-section rates
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Mental Health Utilization
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Emergency room visits/1,000 beneficiaries - under the age of 19
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Missouri Department of Insurance monitors and tracks Helath Plan stability/financial/cost of care

Health Plan/ Provider Characteristics:

-Languages Spoken (other than English)

Beneficiary Characteristics:

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

MISSOURI

MC+ Managed Care/1115

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:

-ADHD
-Asthma management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care

Non-Clinical Topics:

-Adult's access to primary care practitioners
-Children's access to primary care practitioners
-Customer Service and Prior Authorization

Standards/Accreditation

MCO Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:

None

EQRO Name:

-Behavioral Health Concepts (BHC)

EQRO Organization:

-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:

-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

Program Payers:

Medicaid is the only payer

Population Categories Included:

A subset of MCO members, defined by beneficiary age

Rewards Model:

Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

Clinical Conditions:

Childhood immunizations
Well-child visits

Measurement of Improved Performance:

State measures MCO achievement in reaching established standards of outcome measures

Initial Year of Reward:

2001

Evaluation Component:

The State has conducted an evaluation of the effectiveness of its P4P program

NEW YORK

Partnership Plan - Family Health Plus

CONTACT INFORMATION

State Medicaid Contact:

Linda LeClair
Office of Medicaid Managment, NYS Dept of Health
(518) 474-8887

State Website Address:

http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
June 29, 2001

Implementation Date:
September 04, 2001

Waiver Expiration Date:
September 30, 2009

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(30) UPL Limits
-1902(a)(34) Retroactive Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Disenrollment
-1903(u) MEQC
-Eligibility Expansion
-Family Planning
-Guaranteed Eligibility
-Inst. For Mental Disease
-Insurance Reimbursement
-MCO misc 1903(m)(2)(A)(xi) DEs grievance procedures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Diabetic supplies and equipment, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medically Managed Detox - Inpatient, Medically Supervised Withdrawal Services Inpatient/Outpatient, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy,

Allowable PCPs:
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Qualified Obstetricians/Gynecologists

Physician, Radiation Therapy, Chemotherapy, Hemodialysis, Smoking cessation products, Transportation, Vision, X-Ray

Enrollment

Populations Voluntarily Enrolled:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 w/children up to 150% FPL

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Equivalent Insurance
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

NEW YORK
Partnership Plan - Family Health Plus

PPO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Diabetic supplies and equipment, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medically Necessary Detox Inpatient, Medically Supervised withdrawal service Inp/Out, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Radiation therapy, Chemotherapy, Hemodialysis, Smoking cessation products, Transportation, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Pediatricians
-Internists
-General Practitioners
-Family Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Qualified Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 w/children up to 150% of FPL

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program
-Other Equivalent Insurance

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
Capital District Physicians Health Plan
Community Choice Health Plan
Excellus
GHI HMO Select
Health Now
HIP Combined
MetroPlus Health Plan
Americhoice of New York
CarePlus Health Plan
Community Premier Plus
GHI
Health First
HealthPlus
Hudson Health Plan
MVP Health Plan

NEW YORK
Partnership Plan - Family Health Plus

Neighborhood Health Providers
NY State Catholic Health Plan/Fidelis
St. Barnabas/Partners in Health
United Healthcare of Upstate
Wellcare
NY Presbyterian Hospital Health Plan
SCHC TotalCare
United Healthcare of NY
Univera Community Health

ADDITIONAL INFORMATION

MCO Included Services: Family Planning and Dental is included at the MCO Option. Home Health is limited for 40 visits; Inpatient Mental Health is limited to 30 days per year; Outpatient Mental Health is limited to 60 days per year. The PPO is offered incentives where there is no contracted MCO. PPO Included Services: Dental is included at the MCO Option. Inpatient Mental Health is limited to 30 days per year; Outpatient Mental Health is limited to 60 days per year; Home Health is limited to 40 visits. Both MCO and PPO provide emergency available transportation.

The PPO managed care entity performs the same Quality Activities as the MCO.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Health Services Research
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
None

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

NEW YORK

Partnership Plan - Medicaid Advantage

CONTACT INFORMATION

State Medicaid Contact:

Karen Kalajian
Office of Managed Care
518 473-1134

State Website Address:

http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
January 01, 2005

Implementation Date:
May 01, 2005

Waiver Expiration Date:
September 30, 2009

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10) Access to Federally Qualified Health Clinics
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(3) Access to State Fair Hearing
-1902(a)(30) Upper Payment Limit
-1902(a)(34) Retroactive Coverage

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Disenrollment
-1903(u) MEQC
-Eligibility Expansion
-Family Planning
-Guaranteed Eligibility
-Inst. For Mental Disease
-Insurance Reimbursement
-MCO misc 1903(m)(2)(A)(xi) - DE grievance procedures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulance, Bone Mass Measurement, Chiropractic, Colorectal Screening, Dental, Diabetes Monitoring, Durable Medical Equipment, Emergency Room, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory,

Allowable PCPs:
-Not Applicable

Mammograms, Non-covered Medicare visits, Occupational Therapy, Outpatient Mental Health, Outpatient Substance Use Disorders, Outpatient Surgery, Pap Smear and Pelvic Exams, PCP visits, Physical Therapy, Podiatry, Private Duty Nursing, Prostate Cancer Screening, Prosthetics, Radiation therapy, Routine Physical Exam - 1 year, Skilled Nursing Facility, Specialty Office Visits, Speech Therapy, Transportation, Urgent Care, Vision, X-Ray

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Eligible less than 6 months
-In the LTHHCP, except for the DD
-Eligible for TB related services only
-Placed in a State OMH family care home
-In the Restricted Recipient Program
-Enrolled in hospice at the time of enrollment
-Eligible for Family Planning services only
-Elilgible for treatment for breast or cervical cancer only
-Persons with ESRD at the time of enrollment, unless meet the Medicare exception
-Spend downs
-Residents of State operated Psych facilites or residents of State certified treatment facilities for children and youth
-Individuals enrolled in a long term care demonstration
-Other Insurance
-Eligible for the Medicaid buy-in for the working disabled program who pay a premium
-Residents of Residential Health Facility at enrollment whose stay is classified as premanent
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
QMB with full Medicaid coverage

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

NEW YORK

Partnership Plan - Medicaid Advantage

Strategies Used to Identify Persons with Complex (Special) Needs:

-Requires MCOs to identify through assessments

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New York/Medicaid Advantage
GHI/Medicaid Advantage
Liberty Health Advantage/Medicaid Advantage
Neighborhood Health Provider/Medicaid Advantage
GHI HMO Select
HIP Health Plan/Medicaid Advantage
Managed Health Inc/Medicaid Advantage
NYS Catholic Health Plan/Fidelis/Medicaid Advantage

ADDITIONAL INFORMATION

The Medicaid Advantage program strictly serves dual eligibles. Only the transportation and dental services are optional outside of NYC. Within NYC, these services are required.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-MCOs must comply with Medicare requirements for quality in 42 CFR 422

Consumer Self-Report Data:

None

Use of Collected Data:

-Program Evaluation
-Regulatory Compliance/Federal Reporting

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

None

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons

to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
No

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Mandatory Activities:
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

NEW YORK
Partnership Plan Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:	Elizabeth McFarlane Office of Managed Care, New York State Department (518) 473-0122
State Website Address:	http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 15, 1997

Implementation Date:
October 01, 1997

Waiver Expiration Date:
September 01, 2009

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(3) Access to State Fair Hearing
-1902(a)(30) UPL Limits
-1902(a)(34) Retroactive Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Disenrollment
-1903(u) MEQC
-Eligibility Expansion
-Family Planning
-Guaranteed Eligibility
-Inst. For Mental Disease
-Insurance Reimbursement
-MCO misc 1903(m)(2)(A)(xi) DE grievance procedures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy,

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Qualified Obstetricians/Gynecologists

Transportation, Vision, X-Ray

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR
-Partcipation in LTC Demonstration Program
-Other Insurance
-Eligible less than 6 Months
-Spend downs
-Reside in State Operated Psychiatric facility
-Enrolled in the Restricted Recipient Program
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Special Needs Children (State defined)
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-NYS Safety Net Adults

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Pediatricians
-Internists
-General Practitioners
-Family Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Qualified Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Special Needs Children (State defined)
-Admitted to hospice at the time of enrollment
-Reside in Nursing Facility or ICF/MR
-Participation in a LTC Demonstration Program
-Other Insurance
-Eligible less than 6 Months
-Spend downs
-Reside in State Operated Psychiatric Facility
-Enrolled in the Restricted Recipient Program
-Foster care children in direct care
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Reside in Residential Treatment Facility for children and youth

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PCCM Provider - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Qualified Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Eligible less than 6 months
-Spend downs
-Reside in State Operated Psychiatric Facility
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Medicare Dual Eligibles
-Foster Care children in direct care
-Eligible only for TB Related Sevices
-Reside in residential treatment facility for children and yourth
-Special Needs Children (State defined)
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR
-Participation in LTC Demonstration

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

NEW YORK

Partnership Plan Medicaid Managed Care Program

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
Broome County MC
CarePlus Health Plan
Community Premier Plus
GHI HMO Select
Health Now
Hudson Health Plan
Managed Health Inc/A+ Health Plan
MetroPlus Health Plan
MVP Health Plan
NY Presbyterian Hospital Health Plan
NYPS Select Health SN
Physician Case Management Program
SCHC TotalCare
Southern Tier Priority
Suffolk Health Plan
United Healthcare of Upstate
VidaCare Inc. Special Needs
Americhoice of New York
Capital District Physicians Health Plan
Community Choice Health Plan
Excellus
Health First
HIP Combined
Independent Health/Hudson Valley&WNY
Manhattan PHSP/Centercare
MetroPlus Health Plan Special Needs
Neighborhood Health Providers
NY State Catholic Health Plan/Fidelis
NYPS Select Health Special Needs
Preferred Care
Southern Tier Pediatrics
St. Barnabas/Partners in Health
United Healthcare of NY
Univera Community Health
Wellcare

ADDITIONAL INFORMATION

MCO Included Services: Dental, Family Planning, and Transportation are included at the option of the MCO. Monthly premium for primary care services and medical case management.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

NEW YORK
Partnership Plan Medicaid Managed Care Program

Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Alcohol and Substance abuse use screening
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead Screening rate
-Smoking prevention and cessation
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Inpatient maternity care and discharge planning
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Clinical Conditions:
Asthma
Childhood immunizations
Depression
Diabetes
Measure Change in Performance Annually
Prenatal Care
Well-child visits

Initial Year of Reward:
2000

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs

Measurement of Improved Performance:
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-On-Site Reviews
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality:
None

Access/Availability of Care:
None

Provider Characteristics:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
-Number of primary care case manager visits per beneficiary

Beneficiary Characteristics:
None

OKLAHOMA
SoonerCare

CONTACT INFORMATION

State Medicaid Contact:	Rebecca Pasternik-Ikard Oklahoma Health Care Authority (405) 522-7300
State Website Address:	http://www.ohca.state.ok.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
LifeCare

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 12, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2009

Sections of Title XIX Waived:
-1902(a)(17) - Counting Income and Comparability of Eligibility
-1902(a)(23) Freedom of Choice
-1902(a)(34) - Retroactive Eligibility
-1902(a)(4) - Prapaid Ambulatory Health Plan Enrollment

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Expenditures for costs related to the Disease Management Program
-Expenditures for expanded coverage for individuals who are non-disabled low income workers and their spouses
-Expenditures for expanded coverage for individuals who are working disabled adults
-Expenditures for reimbursing out-of-pocket costs in excess of five percent of annual gross income for O-EPIC beneficiaries

SERVICE DELIVERY

PCCM Provider - Non-risk Capitation

Service Delivery

Included Services:
Case Management

Allowable PCPs:
-Indian Health Service (IHS) Providers

Enrollment

OKLAHOMA

SoonerCare

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Children in permanent custody
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Covered by an HMO

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Medical-only PAHP (risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Immunization, Laboratory, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Indian Health Service (IHS) Providers
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-American Indian/Alaskan Native
-Poverty-Level Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Children In State Custody
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in private HMO

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

OKLAHOMA
SoonerCare

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerCare American Indian PCCM

SoonerCare PAHP

ADDITIONAL INFORMATION

American Indians are the only population that is eligible to enroll in the PCCM portion of the SoonerCare program. The Primary Care Provider/Case Manager is capitated for case management for each enrollee. American Indians have an option of enrolling in the PCCM or Medical-only PAHP under the SoonerCare program. Enrollment is mandatory for all covered populations.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
Adult Behavioral Health Care Services ECHO
Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and

encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Dental services
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

OKLAHOMA
SoonerCare

Beneficiary Characteristics:
-Percentage of beneficiaries who are auto-assigned to PCP

Performance Improvement Projects

Project Requirements:

-All PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Behavioral Health care for children
-Comprehensive diabetes care
-Emergency Room service utilization
-Reducing health care disparities
-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

PAHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Adult Behavioral Health Care Services ECHO Survey
-CAHPS
  Child Medicaid AFDC Questionnaire

Performance Measures

Process Quality:
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Dental services
-Diabetes management/care
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

OKLAHOMA
SoonerCare

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Clinical Topics:
-Emergency Room service utilization
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

OREGON

Oregon Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Lynn Read
Office of Medical Assistance Programs
(503) 945-5767

State Website Address:

http://www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
March 19, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
October 31, 2007

Sections of Title XIX Waived:

-1902(a)(10)
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(A)
-1902(a)(14) Cost Sharing
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(43)(A)
-1903(m)(1)(a)
-1903(m)(2)(a)
-1903(m)(2)(a)(vi)
-1905(a)(13)
-2103
-2103(e)

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(f)
-1903(m)(1)(A)
-1903(m)(2)(A)
-1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee Eligibility, Disenrollment
-1905(a)(13) Chemical Dependency Treatment
-Employer Sponsored Insurance
-Inst. For Mental Disease

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders, Screening, Identification, and Brief Intervention

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women
-Medicare Dual Eligibles
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Physician

Allowable PCPs:
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Family Practitioners
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Pediatricians
-General Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Does not apply

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Medicare Dual Eligible
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown
-Other Insurance

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

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MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-QMB and MN Spenddown
-Other Insurance
-Enrolled in Another Managed Care Program

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Barbituates
-Benzodiazepines

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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Oregon Health Plan

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Health Plans use multiple means to identify such members
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Employment Agencies
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Accountable Behavioral Health
Care Oregon
Central Oregon Independent Health Solutions
Deschutes County CDO
Douglas County IPA
FamilyCare Health Plans
Hayden Family Dentistry
Jefferson Behavioral Health
Lane Individual Practice Association
Marion Polk Community Health Plan
Mid-Rogue Independent Practice Assoc.
Multnomah County Verity
Oregon Dental Service
PCCM
Tuality Health Care
Willamette Dental

Capitol Dental Care Inc.
Cascade Comprehensive Care
Clackamas County Mental Health
Doctors of the Oregon Coast South
FamilyCare (Mental Health)
Greater Oregon Behavioral Health, Inc.
Inter-Community Health Network
Lane Care MHO
Managed Dental Care of Oregon
Mid Valley Behavioral Care Network
Multicare Dental
Northwest Dental Services
Oregon Health Management Service
Providence Health Assurance
Washington County Health (Mental Health)

ADDITIONAL INFORMATION

1902(a)(1) Statewideness was waived under the uniformity section. A $6.00 Case Management Fee is paid on a per member/per month basis. This fee is not a capitation payment. The Oregon PCCM program is fee-for-service. Under age one is guaranteed 12 months continuous eligibility.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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Consumer Self-Report Data:
-CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
  - Adult with Special Needs Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child Medicaid SSI Questionnaire
  - Child with Special Needs Questionnaire

-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality:
-Patient satisfaction with care

-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Clinical Topics:
-Asthma management
-Childhood Immunization
-Early Childhood Cavities Prevention
-Smoking prevention and cessation

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-OMPRO

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Rapid Cycle Review

-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Consumer Self-Report Data:
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Ratio of mental health providers to number of beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Clinical Topics:
-Coordination of primary and behavioral health care
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

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Oregon Health Plan

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-OMPRO

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-Disenrollment Survey

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service

State conducts general data completeness assessments:
Yes

-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Performance Measures

Process Quality:
-Dental services

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Ratio of dental providers to beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-PAHP/PCP-specific disenrollment rate

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Early Childhood Cavities Prevention
-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:

-All PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:

-Grievance Systems

Clinical Topics:

-Child/Adolescent Dental Screening and Services
-Early Childhood Dental Cavities
-Hospital Dentistry

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

QUALITY ACTIVITIES FOR PCCM

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Oregon Health Plan

Quality Oversight Activities:

- -Consumer Self-Report Data
- -Enrollee Hotlines
- -Focused Studies
- -Ombudsman

Consumer Self-Report Data:

-CAHPS

- "Cores" Adult/Child Survey with elected Medicaid and Special Needs Questions

Use of Collected Data:

- -Health Services Research
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

RHODE ISLAND
Rite Care

CONTACT INFORMATION

State Medicaid Contact:	Deborah J. Florio Center for Child & Family Health (401) 462-0140
State Website Address:	http://www.dhs.state.ri.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
July 31, 2008

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A) - Managed Care Organization
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD
-Expenditures for enhanced benefits
-Expenditures for enhanced benefits
-Extended Family Planning
-Premium Assistance

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Physician Assistants
-Indian Health Service (IHS) Providers
-School-based health clinics
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Nurse Practitioners

RHODE ISLAND
Rite Care

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage
-Special Needs Children with Other Insurance Coverage

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Pregnant Women above Poverty Level
-Poverty-Level Pregnant Women

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Chlid Welfare Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross & Blue Shield of Rhode Island

Neighborhood Health Plan of Rhode Island

RHODE ISLAND
Rite Care

United HealthCare of New England

ADDITIONAL INFORMATION

Since September, 2003, Children with Special Health Care Needs are offered enrollment in Rite Care unless they have comprehensive medical insurance from another source -- these children include SSI recipients, children eligible through Katie Beckett provisions, and children in subsidized adoption settings. Managed care enrollment is currently voluntary for these groups, but is not offered if children are covered by comprehensive third-party insurance. Coordination with other agencies in the care of Children with Special Health Care Needs takes place through the CEDARRS program, available to children in managed care as well as to those in fee-for-service Medicaid -- this program combines evaluation, diagnosis, referral, reevaluation and a range of other services for families of Children with Special Needs.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-EQRO
-Focused Studies
-Grievances and Appeals
-MCO Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
-Consumer Advisory Committee
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

None

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison of State data with plan-specifc data

-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Monitoring submision processes from providers to health plans to assure complete and timely submissions
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adolescents' Access to PCPs
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Complaint Resolution Statistics
-Members receive followup within 30 days post behavioral health discharge
-Patient/Member Satisfaction with Access to Care
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Discharges from Neonatal Intensive Care Unit per 1,000 live births
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient days per 1,000
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Prescriptions per 1,000 population by category (name brand, generic and OTC)
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Behavioral health followup after hospitatlization for mental illness
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Chlamydia screening
-Diabetes management
-Lead toxicity
-Post-natal Care
-Pre-natal care

Non-Clinical Topics:
-Member satistisfaction
-Turnaround time for resolving member complaints

Standards/Accreditation

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-IPRO, Inc.

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Detailed technical report for each MCO
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance

Program Payers:
Medicaid is the only payer

RHODE ISLAND

Rite Care

program with MCO

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Clinical Conditions:
Asthma
Childhood immunizations
Depression
Diabetes
Lead Screening Rates
Prenatal Care
Well-child visits

Initial Year of Reward:
2002

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

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CONTACT INFORMATION

State Medicaid Contact:

J.D. Hickey
TennCare
(615) 507-6444

State Website Address:

http://www.state.tn.us/tenncare

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months eligibility for medically needy and guaranteed eligibility for pregnant women

Initial Waiver Approval Date:
November 18, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(c)
-1902(a)(13)(A)
-1902(a)(17)
-1902(a)(19)
-1902(a)(23) Freedom of Choice
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)(a)
-1902(a)(54)
-1902(a)(8)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A)
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, IMD

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Internists

Use Disorders, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:

-SSI eligible children
-Institutionalized children

Subpopulations Excluded from Otherwise Included Populations:

-Children in state custody or leaving state custody
-Enrollees living out of state temporarily
-Enrollees living in areas with insufficient MCO
-Enrollees living in areas with insufficient MCO capacity
-Aliens covered for emergency medical services

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Populations Mandatorily Enrolled:

-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-SSI eligible children
-Institutionalized children
-Medicare Dual Eligibles

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

Yes

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

No

Part D - Enhanced Alternative Coverage:

Not Applicable

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Detoxification, Inpatient Mental Health, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders Services, Pharmacy, Prevention Programs (MH), Prevention Programs (SUD), Residential Substance Use Disorders Treatment Programs, Screening, Identification, and Brief Intervention, Substance Use Disorders Support Services

Allowable PCPs:
-Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medically needy
-Uninsured
-Uninsurables
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Individuals not qualifying under traditional Medicaid criteria

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Dental Benefit Manager - Administrative Services Fee

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Individuals over 21

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Pharmacy Benefit Manager - Administrative Services Fee

Service Delivery

Included Services:
Pharmacy

Allowable PCPs:
-Pharmacists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Foster Care Children
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Individuals not qualifying under traditional Medicaid

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for symptomatic relief of cough and colds
-Nonprescription drugs

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Mental Health Agency

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PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Doral Dental of Tennessee, LLC
John Deere
Preferred Health Partnership/PHP
TennCare Select
UAHC Omnicare
Volunteer State Health Plan (Bluecare)
First Health Services Corporation
Memphis Managed Care Corp. (TLC)
Premier Behavioral Systems of TN
Tennessee Behavioral Health, Inc.
Unison Health Plan (BHP)
Windsor (VHP Community Care)

ADDITIONAL INFORMATION

All medically necessary services are provided through the managed care organizations. All mental health and substance use disorder services are provided through behavioral health organizations except that MCOs cover these services in the middle region. The State has carved out Pharmacy services for eligible TennCare enrollees. Nonprescription drugs and those used for symptomatic relief of cought and colds are covered for children under age 21. Prenatal vitamins and fluoride preparations are covered under Pharmacy. TennCare also has carved out dental services available to enrollees under 21 years only. All Title XIX Medicaid services are covered except Long Term Care and Medicare crossovers. Not all categories included in TennCare are mandatory Medicaid categories. The Dental Benefits Manager and Pharmacy Benefits Manager are administrators (ASO) and are paid an Administrative Services fee. The managers handles claims administration and are reimbursed for the paid claims amount(s).

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Child with Special Needs Questionnaire
  Medicaid Adult Questionnaire
  Medicaid Child Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of Collected Data:
-ANOVA (Analysis of Variance)
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

data submission

Collection: Standardized Forms:
-8370 or ADA - American Dental Association dental claim format
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

-Use of unique identification numbers (such as SSN, Medicaid identifications) for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Breast cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes management/care
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Heart Failure care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

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Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Annual Financial Statements
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Quarterly Financial Statements
-State minimum reserve requirements
-Total revenue
-Weekly Claims Inventory Reports

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Clinical Topics:
-Asthma management
-Diabetes management
-Pre/Post Maternity Care Management with a High-Risk Focus
-Well Child Care/EPSDT

Standards/Accreditation

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Q-Source

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of Provider Networks

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Diabetes
Prenatal Care
Well-child visits

Initial Year of Reward:
2006

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and

Medicaid agency

Collection: Standardized Forms:
-8370 or ADA American Dental Association dental claim format
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Inpatient admissions/1,000 beneficiary

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

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Project Requirements:
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services

Clinical Topics:
-Childhood Immunization
-Well Child Care/EPSDT

Standards/Accreditation

PIHP Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)

EQRO Name:
-Q-Source

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
None

UTAH
Primary Care Network (PCN)

CONTACT INFORMATION

State Medicaid Contact:

Heidi Weaver
Utah Department of Health
(801) 538-6806

State Website Address:

http://www.state.ut.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 08, 2002

Implementation Date:
July 01, 2002

Waiver Expiration Date:
June 30, 2010

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(14) Enrollment Fee
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs
-1902(a)(43)(A) EPDST

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-Eligibility Expansions

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Diabetes Products, Durable Medical Equipment, Emergency Room Services, Emergency Transportation, Family Planning, Immunization, Laboratory, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Pediatricians
-Federally Qualified Health Centers (FQHCs)
-Indian Health Service (IHS) Providers

Enrollment

UTAH
Primary Care Network (PCN)

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Section 1925 (Traditional Medical Assistance) Adults
-High risk pregnant women
-Adults age 19 and above at 150% of the FPL

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Special Needs Children (BBA defined)
-Other Insurance

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Transportation

Contractor Types:
-CMHC Operated Entity (Public)
-County Operated Entity (Public)
-CMHC - some private; some governmental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Resident of the Utah State Hospital (IMD)
-Resident of the State Developmental Center (DD/MR facility)
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Section 1925 (Traditional Medical Assistance) Adults
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

UTAH
Primary Care Network (PCN)

Medical-only PIHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supples, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Skilled Nursing Facility (less than 30 days), Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Section 1925 (Traditional Medical Assistance) Adults

Subpopulations Excluded from Otherwise Included Populations:
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)
-During Retroactive Eligibility Period
-If approved as exempt from mandatory enrollment
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
Davis Mental Health
Healthy U
Molina Healthcare of Utah (Molina Plus)
Central Utah Mental
Four Corners Mental Health
IHC Health Plans Inc.
Molina Healthcare of Utah (Molina)

UTAH
Primary Care Network (PCN)

Northeastern Counseling Center
Valley Mental Health
Weber Mental Health
Southwest Mental Health
Wasatch Mental Health

ADDITIONAL INFORMATION

PCN program is a statewide section 1115 demonstration to expand Medicaid coverage. PCN also offers the full Medicaid state plan package to certain high-risk pregnant women with assets in excess of state plan levels, and a primary/preventive package to certain adults age 19 and above, with incomes under 150% FPL, who are not otherwise Medicaid-eligible. The PIHP contracts covering physical health care are non-risk. Medicaid reimburses each of these contractors for services. The PIHP contracts covering mental health care are risk-based. Payment is a non-risk arrangement. Skilled Nursing Facility services are provided for less than 30 days under the PIHP. Only Emergency Transportation is provided under the PCCM.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Consumer Self-Report Data:

-State-developed Survey

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across PIHPs

UTAH

Primary Care Network (PCN)

PIHP conducts data accuracy check(s) on specified data elements:

-Date of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Duplicate Service
-Place of Service

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of low birth weight infants
-Recidvism
-Symptom reduction

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average time for intake
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:

-Information of beneficiary ethnicity/race
-Information on age and gender
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own

Clinical Topics:

-Coordination of primary and behavioral health care choosing

Non-Clinical Topics:
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Health Services Advisory Group, Inc.

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult with Special Needs Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

VERMONT
Global Commitment to Health

CONTACT INFORMATION

State Medicaid Contact:

Joshua Slen
Office of Vermont Health Access
(802) 879-5900

State Website Address:

http://www.dsw.state.vt.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
September 27, 2005

Implementation Date:
October 01, 2005

Waiver Expiration Date:
September 30, 2010

Sections of Title XIX Waived:
-1902(1)(17)
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(c)(i)
-1902(a)(14)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1902(a)(4)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(i)(10) Drug-related expenditures
-1903(m)(2)(A)(vi) Eligibility Expansion, Guaranteed Eligibility, IMD
-Expenditures for payments to MCOs that restrict disenrollment rights

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Indian Health Service (IHS) Providers
-Obstetricians/Gynecologists
-General Practitioners
-Family Practitioners

-Internists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Spenddown
-Children who participate in Vermont High Tech Home Care Program
-Other Insurance
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for anorexia, weight loss, weight gain
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency

-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Global Commitment to Health

ADDITIONAL INFORMATION

Vermont Health Access program expired September 30, 2005. Global Committment to Health program began October 1, 2005. Under this demonstration the Vermont Agency of Human Services will contract with the Office of Vermont Health Access (OVHA) which will serve as a publically sponsored managed care organization (MCO).

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-Performance Improvements Projects (see below for details)

Consumer Self-Report Data:

-CAHPS
 Adult Medicaid AFDC Questionnaire

Use of Collected Data:

-Track Health Service provision

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:

-State DID NOT provide any requirements for encounter data collection

Collection: Standardized Forms:

None

Collections: Submission Specifications:

None

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

VERMONT

Global Commitment to Health

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:

Yes

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:

-Co-occuring Disorders Project

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:

None

EQRO Name:

-Vermont Program for Quality in Healthcare

EQRO Organization:

-QIO-like entity

EQRO Mandatory Activities:

-Validation of performance improvement projects

EQRO Optional Activities:

None

Pay for Performance (P4P)

Implementation of P4P:

The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:

Not Applicable

Population Categories Included:

Not Applicable

Rewards Model:

Not Applicable

Clinical Conditions:

Not Applicable

Measurement of Improved Performance:

Not Applicable

Initial Year of Reward:

Not Applicable

Evaluation Component:

Not Applicable

WISCONSIN
BadgerCare [SCHIP]

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

http://dhfs.wisconsin.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
April 01, 1999

Implementation Date:
July 01, 1999

Waiver Expiration Date:
March 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-Annual Reporting Requirements
-Eligibility and Outreach
-Eligibility Expansion
-Federal Matching Payment and Family Coverage Limits
-Restrictions on Coverage and Eligibility to Targeted Low Income Children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

WISCONSIN
BadgerCare [SCHIP]

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- -Medicare Dual Eligibles
- -Migrant workers
- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -American Indian/Alaskan Native
- -Residents residing in FFS counties

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
- -TITLE XXI SCHIP
- -Custodial Parents (And Their Spouses) Of Children Eligible Through Title XXI SCHIP (BadgerCare)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Reviews complaints and grievances to identify members of these groups
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -County Departments for Mental Health, Substance Abuse, Social Services, Etc.
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency
- -Social Services Agency
- -Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Abri Health Plan -- BadgerCare (SCHIP)

Compcare (formerly Atrium Health Plan) -- BadgerCare SCHIP

Group Health Cooperative Of Eau Claire -- BadgerCare SCHIP

Children's Community Health Plan - Badgercare

Dean Health Plan -- Badger Care (SCHIP)

Group Health Cooperative Of South Central WI -- BadgerCare SCHIP

WISCONSIN

BadgerCare [SCHIP]

Health Tradition Health Plan -- BadgerCare SCHIP
MercyCare Insurance Company -- BadgerCare SCHIP
Security Health Plan -- BadgerCare SCHIP
Unity Health Insurance -- BadgerCare SCHIP
Managed Health Services -- BadgerCare SCHIP
Network Health Plan -- BadgerCare SCHIP
UnitedHealthcare of WI -- BadgerCare SCHIP

ADDITIONAL INFORMATION

BadgerCare is the Wisconsin Title XXI SCHIP managed care program. It has the same benefit package and contracts with the same HMO plans as the Wisconsin Medicaid HMO Program. BadgerCare enrolls children and parents with specific requirements for income level, lack of other insurance coverage, and other factors. On 07/01/1999, BadgerCare began operating under an 1115 demonstration waiver initially approved on 04/01/1999 and amended on 01/18/2001. Other special circumstances: enrollment varies by county; summary and detailed claims data required; HMOs required to coordinate with WIC, county non-MA programs, and other local agencies and programs.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Satisfaction Survey
-External Quality Review
-MCO Report Card
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Non-Duplication of Mandatory EQR Activities Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Quality Improvement Goal Setting

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

State conducts general data completeness assessments:

No

Performance Measures

Process Quality:

-Breast Cancer screening rate
-Cervical cancer screening rate
-Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years,6-14 years, and 15-20 years
-Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14 years and 15-20 years
-Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5,6,and 7, or more visits
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals of all ages
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals of all ages

Health Status/Outcomes Quality:

-Breast malignancies detected
-Cervix/uterus malignancies detected
-HPV infections detected
-Patient satisfaction with care

Access/Availability of Care:

-Average distance to PCP
-Provider network data on geographic distribution
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Percentage of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Percentage of beneficiaries with at least one PCP visit
-Percentage of beneficiaries with at least one specialist visit

Health Plan Stability/ Financial/Cost of Care:

None

Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Antibiotic Resistance
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Improving Birth Outcomes Project
-Lead toxicity
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards
-URAC (previously known as Utilization Review Accreditation Committee) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC (previously known as Utilization Review Accreditation Committee) Standards

EQRO Name:
-MetaStar

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

WISCONSIN
BadgerCare [SCHIP]

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

WISCONSIN
Wisconsin Partnership Program

CONTACT INFORMATION

State Medicaid Contact:	Monica Deignan DHFS/DDES/BLTS-MCS (608) 261-7851
State Website Address:	http://dhfs.wisconsin.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1998

Implementation Date:
January 01, 1999

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)
-1902(a)(20)
-1902(a)(23) Freedom of Choice
-1902(a)(7)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-HCBS

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-All certified Medicaid providers

Enrollment

WISCONSIN

Wisconsin Partnership Program

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus

Populations Mandatorily Enrolled:

None

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care Health Plan
Community Living Alliance
Community Health Partnership -- Partnership
Elder Care Of Dane County - Partnership

ADDITIONAL INFORMATION

The Wisconsin Partnership Program began operating under a dual Medicaid--Medicare waiver in January 1999. This demonstration project provides comprehensive Medicaid and Medicare services for older adults (ages 65+) and people with physical disabilities (ages 18-64). The Partnership Program integrates health and long-term support services and includes home- and community-based care, physician services, and all other medical care. Services are delivered in the participants home or a setting of his or her choice. Team-based care management is a key component of the program. Enrollees must meet nursing home level-of-care. The Partnership Program goals are to: improve quality of health care and service delivery while containing costs; reduce fragmentation and inefficiency in the existing health care delivery system; increase the ability of people to live in the community and participate in decisions regarding their own health care. Other special characteristics: same goals as PACE Program; nurse practitioners play a key role in linking services; recipients can bring their own provider as PCP; external committee evaluation data techniques.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-None

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:
Yes

WISCONSIN

Wisconsin Partnership Program

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
-Number of hospital admissions per member per year
-Number of hospital days per member per year
-Percentage of beneficiaries with at least one dental visit
-Percentage of people living at home, CBRF/group home, nursing home

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-MetaStar

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

WISCONSIN
Wisconsin Partnership Program

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

Section:
1932(a) State Plan Amendments

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CALIFORNIA

Sacramento Geographic Managed Care (CCS/Dental)

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 08, 2004

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency Services, Enhanced Perinatal and Preventive, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Transportation, Tuberculosis, Vision, X-Ray

Allowable PCPs:
-Psychiatrists
-Pediatricians
-Family Practitioners
-Internists
-General Practitioners
-Physician Assistants
-Rural Health Clinics (RHCs)
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers

Enrollment

CALIFORNIA
Sacramento Geographic Managed Care (CCS/Dental)

Populations Voluntarily Enrolled:

-American Indians
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Adoption Assist/Medically Indigent-Child
-Foster Care/Medically Indigent-Child
-Pregnant/Medically Indigent-Adult
-Foster Care Children
-Medicare Dual Eligibles
-PACT

Populations Mandatorily Enrolled:

-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Special Program/Percent/Children
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Public Assistance-Family

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Medicare Dual Eligibles
-Other Insurance
-Enrolled in Another Medicaid Managed Care Program

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for cosmetic purposes or hair growth
-Agents when used for symptomatic relief of cough and colds
-Agents when used to promote fertility
-Barbituates
-Benzodiazepines
-Drugs used to promote fertility
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Adoption Assist/Medically indigent-Child
-Foster Care/Medically indigent-Child
-Pregnant/Medically Indigent-Adult
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Enrolled In Another Medicaid Program
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Long Term Care
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Public Assistance-Family
-Special Program/Percent/Children

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups -

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities
-Education Agency

program linkage and/or family contact
-Uses provider referrals to identify members of these groups

-Home and Community Based Care
-Local Schools
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Title V

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-Sacramento
Care 1st /Sacramento
Health Net-Sacramento
Kaiser Foundation-Sacramento
Molina Medical Centers-Sacramento
Western Health Advantage-Sacramento
Blue Cross of California-Sacramento
Community Dental Services/Sacramento
Kaiser (Dental)-Sacramento
Liberty Dental Plan of CA/Sacramento
Western Dental Services-Sacramento

ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated mandatory to enroll in 1 of 5 health plans and 1 of 4 dental plans. This program operates under the combined authorities of Section 1932(a) and 1915(b). The corresponding 1915(b) waiver is California CCS/ Dental Waiver Program, which provides authority for mandatory enrollment in Sacramento GMC of those populations that would otherwise be excluded from mandatory enrollment under Section 1932(a). The CCS/Dental waiver also provides the authority for the mandatory dental managed care component of Sacramento GMC.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes medication management
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Average distance to PCP

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan/ Provider Characteristics:
-Board Certification

Performance Improvement Projects

CALIFORNIA
Sacramento Geographic Managed Care (CCS/Dental)

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:
-Adolescent Health collaborative statewide
-Blood Lead Level
-Breast Cancer Screening
-Childhood Immunization
-Diabetes management
-Hospital Quality
-Improving Prenatal Services
-Prenatal and Postpartum Care

Non-Clinical Topics:
-Adolescent Health
-Improve Initial Health Assessment

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Does not collect quality data.

Use of Collected Data:
-Not Applicable

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

CALIFORNIA
San Diego Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:	Vanessa Baird Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 08, 2004

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency Services, Enhanced Perinatal and Preventive, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Transportation, Tuberculosis, Vision, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Physician Assistants
-Psychiatrists
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives

Enrollment

CALIFORNIA
San Diego Geographic Managed Care

Populations Voluntarily Enrolled:

-American Indian
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Adoption Assist/Medically Indigent-Child
-Foster Care/Medically Indigent-Child
-Pregnant/Medically Indigent-Adult
-Medicare Dual Eligibles
-PACT(Planning, Access, Care, Treatment)

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Other Insurance
-Enrolled in Another Medicaid Program
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:

-Section 1931 (CALWORKS TANF) Children and Related Populations
-Section 1931 (CALWORKS TANF) Adults and Related Populations
-Public Assistance-Family
-Special Program/Percent/Children

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for cosmetic purposes or hair growth
-Agents when used for symptomatic relief of cough and colds
-Agents when used to promote fertility
-Barbituates
-Benzodiazepines
-Drugs used to promote fertility
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Provides Part D Benefits:

Yes

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabililties
-Education Agency
-Home and Community Based Care
-Local Schools
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

-Social Services Agency
-Substance Abuse Agency
-Title V

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross of California-San Diego
Care 1st Partnership Plan LLC - San Diego
Care 1st/San Diego
Community Health Group-San Diego
Health Net-San Diego
Kaiser Permanente (South) - San Diego (Plan Partner LA Care)
Molina Healthcare of California Partner Plan, Inc. - San Diego
Molina Medical Centers-San Diego

ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated as mandatory to enroll in 1 of 6 health plans. This program operates under the combined authorities of Section 1932(a) and 1915(b). The corresponding 1915(b) waiver is the California CCS/Dental Waiver Program.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes medication management
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to PCP

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care

Clinical Topics:
-Asthma management
-Breast cancer screening (Mammography)
-Childhood Immunization
-Diabetes management
-Postpartum Depression

program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:
-Adolescent statewide collaborative
-Hospital Quality

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Delmarva Foundation

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

CALIFORNIA
Two-Plan Model Program

CONTACT INFORMATION

State Medicaid Contact:	Vanessa Baird Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 08, 2004

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Cultural/Linguistic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Preventive Health Screening, Specialist, Transportation, Vision, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Internists
-Family Practitioners
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistance

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for cosmetic purposes or hair growth
-Agents when used for symptomatic relief of cough and colds
-Agents when used to promote fertility
-Barbituates
-Benzodiazepines
-Drugs used to promote fertility
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Provides Part D Benefits:

Yes

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-California Childrens Services
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alameda Alliance for Health
Blue Cross of California-TPMP
Community Dental Services/LA
Contra Costa Health Plan

CALIFORNIA
Two-Plan Model Program

Health Net-TPMP
Inland Empire Health Plan
LA Care Health Plan
Molina Medical Centers-TPMP
Santa Clara Family Health Plan
Health Plan of San Joaquin
Kern Family Health Care
Liberty Dental Plan of CA-LA
San Francisco Health Plan

ADDITIONAL INFORMATION

Eligibles may choose to join either a local initiative plan or a commercial plan selected by the State. Transportation services are included when medically necessary. This program operates under the combined authorities of Section 1932 (a) and 1915 (b). The corresponding 1915(b) waiver is the California CCS/Dental Waiver Program.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes medication management
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to PCP

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:

-Adolescent Health
-Improve authorized time for Pharmacy

Clinical Topics:

-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Diabetes management
-Increase Hemoglobin A1c Diabetes Management
-Increase Postpartum Visits
-Well Child Care/EPSDT

-Improve Encounter Data - Adolescent Health
-Increasing Specialist reports to PCP
-Initial Health Assessments

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Private accreditation organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Delmarva Foundation

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:	LaRah Payne Department of Health, Medical Assisstance Administrator (202) 724-9116
State Website Address:	http://www.dchealth.dc.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
HOUSTONS INC

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

Populations Voluntarily Enrolled:
-Children receiving adoption assistance
-Special Needs Children (State defined)
-IMMIGRANT CHILDREN (STATE ONLY)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women
-TANF HIV PATIENTS: PREGNANT >26 WEEKS

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP
Health Right Incorporated
DC Chartered Health Plan, Incorporated

ADDITIONAL INFORMATION

Adult Day Treatment applies to Mental Health Retardation. TANF HIV patients can opt out of managed care, pregnant women do not have opt out provision unless they are HIV positive or have AIDS. Children with SSI and SSI Related Diagnosis.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:

None

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

State conducts general data completeness assessments:

Yes

-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:

-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:

-Number of children with diagnosis of rubella(measles)/1,000 children
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:

-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:

None

Beneficiary Characteristics:

None

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Adult hearing and vision screening
-Asthma management
-Beta Blocker treatment after a heart attack
-Child/Adolescent Dental Screening and Services

-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-MCO must be accredited by appropriate body
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

GEORGIA

Georgia Better Health Care

CONTACT INFORMATION

State Medicaid Contact:

Kathy Driggers
Managed Care Division of Department of Community Health
(404) 657-7793

State Website Address:

http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 2002

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Home Health, Immunization, In-home Nursing, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-SOBRA Eligible Pregnant Women
-Medicare Dual Eligibles

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Georgia Better Health Care

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

GEORGIA
Georgia Better Health Care

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-On-Site Reviews
-Performance Measures (see below for details)

Consumer Self-Report Data:
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates

Access/Availability of Care:
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Provider Characteristics:
-Board Certification
-Languages spoken (other than English)

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Beneficiary Characteristics:
-Percentage of beneficiaries who are auto-assigned to PCCM

GEORGIA

Georgia Healthy Families

CONTACT INFORMATION

State Medicaid Contact:

Kathy Driggers
Managed Care Division of Department of Community Health
(404) 657-7793

State Website Address:

http://www.dch.ga.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Disease Management, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Pediatricians
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Nurse Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Public Health Department

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Children (newborn)

-TITLE XXI SCHIP
-Poverty-Level Pregnant Women
-Low-Income Medicaid
-Right from the Start Medicaid
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Refugees
-Women with Breast or Cervical Cancer

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Foster Care
-Long Term Care (includes Hospice)
-Aged, Blind, and Disabled

Medicare Dual Eligibles Included:
None

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Georgia Healthy Families

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
None

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for

Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
None

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Age-appropriate diagnosis/procedure

Collections: Submission Specifications:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Per member per month analysis and comparisons across MCO

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Total revenue

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics:
None

GEORGIA

Georgia Healthy Families

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Depression management
-Diabetes management
-Hospital Discharge Planning
-Lead toxicity
-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-URAC (previously known as Utilization Review Accreditation Committee) Standards

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Organization:
-Private accreditation organization
-QIO-like entity
-Quality Improvement Organization (QIO)
-State entity

Accreditation Required for Participation:
None

EQRO Name:
-None

EQRO Mandatory Activities:
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
A subset of MCO members, defined by beneficiary age

Clinical Conditions:
Well-child visits

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer

service, etc.)

Initial Year of Reward:
2006

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

IOWA

Iowa Medicaid Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:

Dennis Janssen
Department of Human Services
(515) 725-1136

State Website Address:

http://www.dhs.state.ia.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1986

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Pediatricians
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

IOWA
Iowa Medicaid Managed Health Care

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-Nurse Practitioners
-Nurse Midwives
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Health Care

Medipass

ADDITIONAL INFORMATION

Coventry Health Care includes the optional services of Chiropractic and Durable Medical Equipment.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data:

-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements:

-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

None

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Medical record validation

State conducts general data completeness assessments:

Yes

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Prevention of Influenza

-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Iowa Foundation for Medical Care

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

Performance Measures

IOWA
Iowa Medicaid Managed Health Care

Process Quality:
None

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

Provider Characteristics:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries

Beneficiary Characteristics:
None

KANSAS

HealthConnect Kansas

CONTACT INFORMATION

State Medicaid Contact:

Bobbie Graft-Hendrixson
Kansas Health Policy Authority
(785) 296-7010

State Website Address:

http://www.khpa.ks.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS

For All Areas Phased-In:
No

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1984

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Obstetrical, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Physician Assistants
-Pediatricians
-Osteopaths
-Local Health Departments (LHDs)
-Other Specialists Approved on a Case-by-Case Basis
-General Practitioners

Enrollment

KANSAS
HealthConnect Kansas

Populations Voluntarily Enrolled:
-Special Needs Children (BBA-defined)
-Blind/Disabled Children and Related Populations
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Medically Needy-eligible
-Foster Care Children
-Receive Adoption Support
-Spenddown Eligible
-Participate in HCBS Waiver
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Reside in Juvenile Justice Facility
-Reside in State Institution

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from Title V agency to identify members
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect Kansas

ADDITIONAL INFORMATION

KANSAS
HealthConnect Kansas

Beneficiaries choose between the MCO and PCCM programs in counties where an MCO is available. Otherwise, beneficiaries have their choice between PCPs within the PCCM.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Drug Utilization

Provider Characteristics:
None

Beneficiary Characteristics:
None

KANSAS
HealthWave 19

CONTACT INFORMATION

State Medicaid Contact:

Bobbie Graft-Hendrixson
Division of Health Policy and Finance
(785) 296-7010

State Website Address:

http://www.khpa.ks.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Newborn, Nutrition, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Prenatal Health Promotion, Speech Therapy, Transfusions, Transplants, Transportation, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (BBA-defined)

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

-American Indian/Alaskan Native
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in State Hospitals
-Blind/Disabled Adults
-Blind/Disabled Children
-Title XXI SCHIP

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from the Title V agency to identify members
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

FirstGuard Health Plan Kansas, Inc.

ADDITIONAL INFORMATION

In counties were the MCO is available, beneficiaries are allowed to choose between the MCO or other programs that offer PCCM.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-HIPAA 837 electronic submission format
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

State conducts general data completeness assessments:
No

Performance Measures

KANSAS

HealthWave 19

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:

-Asthma treatment outcomes
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:

-Average distance to PCP
-Average wait time for an appointment with PCP
-Panel size
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Drug Utilization

Health Plan Stability/ Financial/Cost of Care:

-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:

-Asthma management
-Low birth-weight baby

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:

-State-Developed/Specified Standards

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:

None

EQRO Name:

-Kansas Foundation for Medical Care

EQRO Organization:

-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

KENTUCKY

Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact:

Neville Wise
Division of Administration & Financial Affairs
(502) 564-8196

State Website Address:

http://chs.state.ky.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2000

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

KENTUCKY

Kentucky Patient Access and Care (KENPAC) Program

Subpopulations Excluded from Otherwise Included Populations:

-Special Needs Children (State defined)
-Spenddown
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Commission for Children with Special Health Care Needs
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Patient Access and Care (KenPAC)

ADDITIONAL INFORMATION

For the following Included services- EPDST, Mental Health, and Maternity Care including prenatal care delivery and post partum beneficiary may go to any participating providers for these services without a referral.

QUALITY ACTIVITIES FOR PCCM

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

Quality Oversight Activities:
-Enrollee Hotlines
-Ombudsman
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

LOUISIANA
Community Care

CONTACT INFORMATION

State Medicaid Contact:	Leah Schwartzman Department of Health and Hospitals (225) 342-9520
State Website Address:	http://www.dhh.state.la.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
ACS Government Healthcare Solutions

For All Areas Phased-In:
No

Guaranteed Eligibility:
Chilldren under 19 have 12 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists
-Pediatricians
-Family Practitioners
-Internists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-General Practitioners
-Nurse Practitioners (under specific conditions)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Recipients who have retroactive eligibility
-Recipients who have other primary insurance that includes physician benefits
-Presumptive Eligible (PE) recipients
-Eligibility Period Less Than 3 Months
-American Indian/Alaskan Native
-Recipients who are 65 or older
-Residents of Psychiatric facilities
-Foster children, or children receiving adoption assistance
-Office of Youth Development recipients
-Recipients in SURS lock-in (except "pharmacy-only" lock in)
-Medically high-risk on a case-by-case basis
-Medicare Dual Eligibles
-CHAMP pregnant women
-Recipients in the Family Planning Waiver Program
-Recipients under the age of 19 in the NOW and Childrens Choice Waiver Programs
-SSI recipients under the age of 19
-Residents of Nursing Facilities or ICF/MR
-Enrollees in the PACE Program
-Recipients under the age of 19 in the Supports Waiver and Supports Waiver SSI Programs
-Recipients in the Hospice Program

-TITLE XXI SCHIP

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints to identify member of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care Program

LOUISIANA
Community Care

ADDITIONAL INFORMATION

Program includes a $3 monthly case management fee. Community Care was converted from a 1915(b) to a 1932(a). Lab and x-ray services are included but services are limited.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
None

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Well-child care visit rates in 3, 4, 5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Children's access to primary care practitioners

Use of Services/Utilization:
-Drug Utilization
-ER visits per 100 beneficiaries
-Inpatient admits per 100 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Clinical Topics:
-Asthma management
-Breast cancer screening (Mammography)
-Diabetes management
-Emergency Room service utilization
-Heart Disease and Stroke
-Well Child Care/EPSDT

Non-Clinical Topics:
-PCP on-office tracking tool used for management of referrals for developmental delays

MAINE

MaineCare Primary Care Case Management

CONTACT INFORMATION

State Medicaid Contact:

Dawn Gallagher
Office of MaineCare Services
(207) 287-9366

State Website Address:

HTTP://www.state.me.us/bms/bmshome.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Public Consulting Group, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Ambulatory Surgical Center, Certain Family Planning, Chiropractic, Clinic, Developmental & Behavioral Evaluation Clinic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatric, Speech/Language Pathology, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Physician Assistants
-Ambulatory Care Clinic or Hospital Based Outpatient Clinic
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Maine Care Children and Parents

- -Women w/ Breast or Cervical Cancer
- -American Indian/Alaskan Native
- -Foster Care Children
- -Children Receiving Adoption Assistance
- -Children with Special Health Care Needs
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -TITLE XXI SCHIP
- -Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Katie Beckett Eligibles
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Individuals on Medicaid recipient restriction program
-Individuals eligible for SSI

Lock-In Provision:
12 months lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MaineCare Primary Care Case Management

ADDITIONAL INFORMATION

Included Services: Certain family planning services and family planning are different in the sense that all family planning services are exempt when provided in a family clinic. Certain family planning services generally refers to services in other setting such as a physicians office. Clinic services may include FQHCs and RHCs.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-HIV/AIDS Survey
-SCHIP Survey
-State-developed Survey

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamydia screening in women
-Dental services
-Diabetes management/care
-HIV/AIDS care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of primary care case managers to beneficiaries

Provider Characteristics:
-Board Certification
-Provider turnover

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

MAINE
MaineCare Primary Care Case Management

Performance Improvement Projects

Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-HIV/AIDS Prevention and/or Management
-Lead toxicity
-Otitis Media management
-Prescription drug abuse
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

MINNESOTA

Minnesota Prepaid Medical Assistance Program-1932(a)

CONTACT INFORMATION

State Medicaid Contact:

Christine Bronson
Minnesota Department of Human Services
(651) 431-2914

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1985

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, ICF/MR, Community-Based Services, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Enrolled in another managed care program

Populations Mandatorily Enrolled:
-Poverty-Level Pregnant Women
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Aged and Related Populations
-TITLE XXI SCHIP
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Non-documented alien recipients who receive only emergency MA under Minn. Stat. 256B.06(4)
-Recipients with terminal or communicable diseases at time of enrollment
-Recipients with private coverage through a MCO not participating in Medicaid
-Refugee Assistance Program recipients
-Recipients residing in state institutions
-Non-institutionalized recipients eligible on spend down basis
-Blind and disabled recipients under age 65
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
PrimeWest Health System
UCARE

First Plan Blue
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1932(a)

CONTACT INFORMATION

State Medicaid Contact:	David Cygan Nebraska Medicaid (402) 471-9050
State Website Address:	http://www.hhs.state.ne.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Nebraska Health Connection/Access Medicaid

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibles
-Transplant Recipients
-American Indian/Alaskan Native
-Special Needs Children (State defined)

Lock-In Provision:

1 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibility
-Transplant Recipients
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-American Indian/Alaskan Native
-Special Needs Children (State defined)

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1932(a)

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Plus

Share Advantage

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming

and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:
None

Clinical Topics:
-Breast Cancer Screening (Mammography)
-Pre-natal care

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance)

Accreditation Required for Participation:
-Department of Insurance Certification

Standards
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
-Medicare+ Choice Accreditation
-NCQA (National Committee for Quality Assurance)

EQRO Organization:
-QIO-like entity

EQRO Name:
-Nebraska Foundation for Medical Care

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-Consumer/beneficiary Focus Groups
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality:
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Immunizations for two year olds
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1932(a)

Access/Availability of Care:

-Average distance to primary care case manager

Use of Services/Utilization:

None

Provider Characteristics:

-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics:

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Improvement Projects

Clinical Topics:

-Adolescent Immunization
-Asthma management
-Childhood Immunization
-Diabetes management

Non-Clinical Topics:

None

NEVADA
Mandatory Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:

Cynthia Leech
Division of Health Care Financing and Policy
(775) 684-3635

State Website Address:

http://www.state.nv.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 31, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practitioner, Chiropractic, Dental, Disposable Medical Supplies, Durable Medical Equipment, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative, Noninvasive Diagnostic Centers, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistants, Podiatry, Prosthetics, Pyschologist, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

NEVADA
Mandatory Health Maintenance Program

Enrollment

Populations Voluntarily Enrolled:
-Seriously Mentally Ill Adults
-Special Needs Children (State defined)
-American Indian
-Severely Emotionally Disturbed Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Residents in Nursing Facilities beyond 45 Days
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Child Health Assurance Program (CHAP)
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of Nevada

NevadaCare DBA Nevada Health Solutions

ADDITIONAL INFORMATION

NEVADA

Mandatory Health Maintenance Program

Temporary Assistance for Needy Families/Child Health Assurance Program is included in the Mandatory Program. Severely Emotionally Disturbed Children, Seriously Mentally Ill Adults, Children with Special Health Care Needs and American Indians are provided voluntary enrollment and/or disenrollment at any time.

Transportation is included but for emergency only.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-State's Quality Assessment and Performance Improvement Strategy and Work Plan

Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Asthma
-Diabetes

Access/Availability of Care:
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

NEVADA
Mandatory Health Maintenance Program

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Health Services Advisory Group

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

Clinical Conditions:
Annual Dental Visits
Asthma
Well-child visits

Initial Year of Reward:
2006

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

NEVADA

Mandatory Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Greg W. Tanner
DHCFP, Managed Care
(775) 684-3708

State Website Address:

www.state.nv.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Special Needs Children (BBA defined)
-Poverty-Level Pregnant Women
-TITLE XXI SCHIP
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-Foster Care Children

NEVADA
Mandatory Non-Emergency Transportation Broker Program

Subpopulations Excluded from Otherwise Included Populations:
-QMB, SLMB, and QI-1

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare

Logisticare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of PAHP Standards
-PAHP Standards
-Provider Data

Consumer Self-Report Data:
None

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data

Collection: Standardized Forms:
None

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility

Collections - Submission Specifications:
None

Validation - Methods:
-Historical Analysis

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

NEW JERSEY

NJ FamilyCare - 1932(a)

CONTACT INFORMATION

State Medicaid Contact:

Jill Simone, M.D.
Office of Managed Health Care
(609) 588-2705

State Website Address:

http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Affiliated Computer Services, Incorporated (ACS)

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Assistive Technology, Audiology, Chiropractor, Dental, Durable Medical Equipment, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Supplies, Optical Appliances, Optometrist, Organ Transplants, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatrist, Post-acute care, Preventive Health Care and Counseling and Health Promotion, Prosthetics, Orthotics, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Nurse Midwives
-Family Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Certified Nurse Specialists
-Pediatricians
-General Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

-Medicare Dual Eligibles

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Non-dual DDD/CCW Adults

Subpopulations Excluded from Otherwise Included Populations:

-Institutionalized in inpatient psychiatric facility
-Medically needy and presumptive eligibility beneficiaries
-Reside in Nursing Facility or ICF/MR
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Division of Youth and Family Services Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.
Health Net of New Jersey, Inc.
University Health Plans, Inc.

AMERIGROUP New Jersey, Inc.
Horizon NJ Health

NEW JERSEY

NJ FamilyCare - 1932(a)

ADDITIONAL INFORMATION

The 12 month lock-in only applies to the TANF and TANF-related populations.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-After-hours Beneficiary Call-in Sessions
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-Network Adequacy Assurance by Plan
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Self-Report Data
-Test 24/7 PCP Availability
-Utilization Review

Consumer Self-Report Data:

-Disenrollment Survey

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

None

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across

MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Comparison of reported changes to reasonable and customary fees

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Childhood Immunizations
-Comprehensive Diabetes Care
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Quality and utilization of dental services
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Lead Toxicity Study

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries
-Ratio of pharmacies to number of beneficiaries

Use of Services/Utilization:
-Average length of stay
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient Days/1,000 beneficiaries
-Pharmacy services/per beneficiaries
-Physician visits/per 1,000 beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Percentage of beneficiaries who are auto-assigned to MCOs

NEW JERSEY
NJ FamilyCare - 1932(a)

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Well Care/EPSDT
-Asthma management
-Birth Outcomes
-Child/Adolescent Dental Screening and Services
-Diabetes management/care
-Lead Screenings
-Postnatal care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:

-Children's access to primary care practitioners
-Encounter Data Improvement
-Hospital Denials and Appeals

Standards/Accreditation

MCO Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Non-Duplication Based on Accreditation:

None

EQRO Organization:

-Quality Improvement Organization (QIO)

Accreditation Required for Participation:

-Department of Banking and Insurance

EQRO Name:

-Healthcare Quality Strategies, Inc. (HQSI)

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:

-Calculation of performance measures
-Conduct studies on access that focus on a particular aspect of clinical and non-clinical services
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record Review
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:

The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:

Not Applicable

Clinical Conditions:

Not Applicable

Initial Year of Reward:

Not Applicable

Program Payers:

Not Applicable

Rewards Model:

Not Applicable

Measurement of Improved Performance:

Not Applicable

Evaluation Component:

Not Applicable

NORTH CAROLINA
Carolina ACCESS

CONTACT INFORMATION

State Medicaid Contact:

Jeffrey Simms
Division of Medical Assistance
(919) 733-2040

State Website Address:

http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Public Consulting Group, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Public Health Departments
-Community Health Centers
-Health Clinics
-Hospital Outpatient Clinics
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Physician Assistants
-Nurse Practitioners

NORTH CAROLINA
Carolina ACCESS

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Medicaid Pregnant Women
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period that is only Retroactive
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Private Insurance and PCP not willing to participate
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
Medicaid Only

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Qualified Aliens

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI
QMB Plus
SLMB Plus

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access

ADDITIONAL INFORMATION

NORTH CAROLINA
Carolina ACCESS

The recipient must choose and enroll with or be assigned to a primary care provider who is paid a monthly case management fee of $1.00 for each enrollee in addition to regular fee for service payments. Enrollment Broker: Public Consulting Group, is only used in Mecklenburg County. Hearing services do not include hearing aids.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics:
-None

Beneficiary Characteristics:
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics:
-Asthma management
-Developmental Screening for Children

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

CONTACT INFORMATION

State Medicaid Contact:	Jeffrey Simms Division of Medical Assistance (919) 733-2040
State Website Address:	http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Public Consulting Group, Inc. (Mecklenburg County Only)

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, Disease Management, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Health Clinics
-Other Specialists Approved on a Case-by-Case Basis
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Health Departments
-Hospital Outpatient Clinics
-Community Health Centers

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-Pregnant Women
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibillity Period that is only Retroactive
-Refugees
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
Medicaid Only

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Qualified Aliens
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI
QMB Plus
SLMB Plus

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses ACCESS II Health assessment form
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care of North Carolina (Access II/III)

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of $2.50 per recipient participating in Access II/III to monitor care and implement disease management initiatives and target preventive studies. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care. Hearing services do not include hearing aids.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:

-Consumer Self-Report Data
-Focused Studies
-Network Data
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
    Adult with Special Needs Questionnaire
    Child with Special Needs Questionnaire
-Consumer/beneficiary Focus Groups
-Disenrollment Survey

Performance Measures

Process Quality:

-Adolescent well-care visits rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cholesterol screening and management
-Depression medication management
-Diabetes management/care
-Heart Failure care
-Immunizations for two year olds
-Influenza vaccination rate
-Smoking prevention and cessation
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:

-Asthma Emergency Department Visit Rates
-Asthma Inpatient Rates
-Conjestive Heart Failure
-Diabetes Inpatient Rates
-ED & Hospitalization Rates
-Patient satisfaction with care

Access/Availability of Care:

-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:

-Ambulatory Care Sensitive Conditions
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient Stays
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

Provider Characteristics:
-Best Practices for Asthma and Diabetes
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of enrollees with chronic illnesses, asthma, diabetes, COPD

Performance Improvement Projects

Clinical Topics:
-Asthma management
-Beta Blocker treatment after a heart attack
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Depression management
-Developmental Screening
-Diabetes management
-Emergency Room service utilization
-Otitis Media management
-Pharmacy management
-Prevention of Influenza

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Practice Readiness for Quality Improvement

NORTH CAROLINA
Health Care Connection

CONTACT INFORMATION

State Medicaid Contact:	Jeffrey Simms Division of Medical Assistance (919) 733-2040
State Website Address:	http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Public Consulting Group

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Adult Preventative Medicine, Ambulance, Chiropractic, Clinic Services, Diagnostic Services, Dialysis, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning and Supplies, Hearing Aids, Home Health, Home Infusion Therapy, Hospice, Immunization, Inpatient Hospital, Laboratory, Midwife, Occupational Therapy, Physical Therapy, Speech Therapy, Optical Supplies, Outpatient Hospital, Physician, Physician Assistants, Family Nurse Practitioners, Podiatry, Postpartum Newborn Home Visits, Maternal Assessment, Newborn Assessment, Private Duty Nursing, Prosthetics/Orthotics, Sterilization, Total Parenteral Nutrition, Vision, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

NORTH CAROLINA
Health Care Connection

Populations Voluntarily Enrolled:

-American Indian/Alaskan Native
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period That Is Only Retro-active
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:

None

Populations Mandatorily Enrolled:

-Pregnant Women
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Wellpath Select, Inc. dba Southcare

ADDITIONAL INFORMATION

Clinic and Inpatient Hospital services does not include mental health or substance use disorders. Physician services include Physician Assistants and Family Nurse Practitioners.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
-Complaints/Grievances/Appeals

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

State conducts general data completeness assessments:

Yes

-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Units of Service

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:

-New Member Health Assessment
-Patient satisfaction with care

Access/Availability of Care:

-Adult's Access to Preventative Services
-Average wait time for an appointment with PCP
-Involuntary Disenrollments
-Non-authorized visits
-PCP Referral Denials
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:

-After Hours Survey
-Enrollment by Product Line
-Languages Spoken (other than English)
-Provider Satisfaction Survey
-Provider turnover

Beneficiary Characteristics:

-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Lead toxicity
-Well Child Care/EPSDT

Non-Clinical Topics:

-Initial Health Assessment/Health Check Review

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Michigan Peer Review Organization (MPRO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

NORTH DAKOTA

North Dakota Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Eric Elkins
North Dakota Department of Human Services Medical Services
(701) 328-2246

State Website Address:

www.nd.gov/humanservices

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mid-level Practitioner, Nutritional, Occupational Therapy, Physical Therapy, Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatry, Private Duty Nursing, Public Health Unit, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Transitional Medicaid
-Section 1931 (AFDC/TANF) Children and Related Populations

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Optional Categorically Needy
-Medically Needy
-Poverty Level

Subpopulations Excluded from Otherwise Included Populations:

-Eligiblity Period that is only Retroactive
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Foster Care
-Refugee Assistance
-Adoption Assistance
-Aged
-Disabled

Lock-In Provision:

6 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

NORTH DAKOTA
North Dakota Medicaid Managed Care Program

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mid-Level Practitioner, Nutritional, Occupational Therapy, Physical Therapy, Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Podiatry, Public Health Unit, Transportation, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Physician Assistants
-Nurse Midwives
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Refugee Assistance
-Adoption Assistance
-Eligibility Period that is only Retroactive
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needy
-Foster Care
-Aged
-Disabled

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Optional Categorically Needy
-Poverty Level

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AltruCare	Primary Care Case Management

NORTH DAKOTA
North Dakota Medicaid Managed Care Program

ADDITIONAL INFORMATION

Transportation services include only non-emergency transportation.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-Health Plan Developed Survey with State Approval

Use of Collected Data:
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:
None

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Number and Type of Services Provided

Beneficiary Characteristics:
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Childhood Immunization
-Depression management
-Diabetes management/care
-Emergency Room service utilization
-Hypertension management
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Smoking prevention and cessation
-Treatment of myocardial infraction
-Well Child Care/EPSDT

Non-Clinical Topics:
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Permedion

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Focused Studies
-Provider Data

Consumer Self-Report Data:
None

Use of Collected Data:
-Beneficiary Provider Selection
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

OHIO

State Plan Amendment for Ohio's full-risk managed care program

CONTACT INFORMATION

State Medicaid Contact:

Jon Barley, Ph.D.
Ohio Department of Job and Family Services
(614) 466-4693

State Website Address:

http://www.state.oh.us/odjfs/index.stm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Private Duty Nurse, RHC, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

OHIO

State Plan Amendment for Ohio's full-risk managed care program

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Medicare Dual Eligibles
-Retroactive Medicaid Eligibility

Medicare Dual Eligibles Included:

None

Lock-In Provision:

No lock-in
12 month lock-in

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Claims Data
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Ohio
CareSource
Molina Healthcare of Ohio
Molina Healthcare of Ohio
Paramount Advantage
Qualchoice Select
Buckeye Community Health Plan
Gateway Health Plan of Ohio
Molina Healthcare of Ohio
Paramount Advantage
Paramount Advantage
Unison Health Plan of Ohio

ADDITIONAL INFORMATION

Ohio operated its managed care program under a 1915(b) waiver through 6/30/05. This was converted to a 1932(a) state plan option effective 7/1/05.[1] Special needs children are children age 17 and under who are pregnant, and members under 21 years of age with one or more of the following: asthma, HIV/AIDS, a chronic physical, emotional, or mental condition for which they need or are receiving treatment or counseling, Supplemental Security Income (SSI) for a health related condition or a current letter of approval from the

OHIO

State Plan Amendment for Ohio's full-risk managed care program

OHIO Department of Health, Bureau of Children with Medical Handicaps.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Performance Incentive System Determination
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCO data certification
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Payment data submission specifications
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

OHIO

State Plan Amendment for Ohio's full-risk managed care program

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rates
-Asthma care - medication use
-Check-ups after delivery
-Dental services
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's access to primary care practitioners

Use of Services/Utilization:
-Ancillary services/1,000 member months
-Behavioral health services/1,000 member months
-Dental visits/1,000 member months
-Drug Utilization
-Durable medical equipment/supply services/1,000 member months
-Emergency room visits/1,000 member months
-Inpatient admissions/1,000 member months
-Maternity/deliveries/1,000 member months
-Primary care visits/1,000 member months
-Vision visits/1,000 member months

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Prompt payment requirements
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Provider panel by specialty and service area
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Children with special health care needs
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs

-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:

-Provider participation in case management activities
-Timely identification, assessment, and case management for members with special health care needs

Clinical Topics:

-Asthma management
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Lead screening
-Pre-natal care
-Well Child Care/EPSDT

Standards/Accreditation

MCO Standards:

-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC (previously known as Utilization Review Accreditation Committee) Standards

Non-Duplication Based on Accreditation:

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC (previously known as Utilization Review Accreditation Committee) Standards

EQRO Organization:

-Quality Improvement Organization (QIO)

Accreditation Required for Participation:

None

EQRO Name:

-Health Services Advisory Group

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:

-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

Program Payers:

Medicaid is the only payer

OHIO

State Plan Amendment for Ohio's full-risk managed care program

Population Categories Included:

A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition
Covers all MCO members

Clinical Conditions:

Adult preventive care visits
Asthma
Case management of children with special health care needs
Child preventive care visits
Dental care
Lead screening
Prenatal Care
Well-child visits

Initial Year of Reward:

2002

Rewards Model:

Payment incentives/differentials to reward MCOs
The state takes back premiums at risk should an MCP fail to meet P4P standards.
There are penalties associated with an MCP's failure to meet performance standards.

Measurement of Improved Performance:

Assessing achievement in access to care (prevention, PCP turnover)
Assessing improvement in clinical quality (by condition) overtime
Assessing improvement in emergency department diversion overtime
Assessing patient satisfaction measures
Assessing the adoption of systematic quality improvement processes
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:

The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

OKLAHOMA
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Rebecca Pasternik-Ikard J.D. RN
Oklahoma Health Care Authority
(405) 522-7208

State Website Address:

www.okhca.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
LogistiCare

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
August 01, 2003

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Special Needs Children (State defined)
-Waiver In-Home Support-Children
-Medicare Dual Eligibles
-Advantage Waiver

Subpopulations Excluded from Otherwise Included Populations:

-Special Low Income Beneficiaries
-Family Planning Waiver
-Supported Living Arrangement (SLA)
-Waiver ADP (W-ADP)
-Waiver In-Home Support-Adult
-W-HIC
-Non-Med (NFMED DDSD)
-Waiver Homeward Bound (W-HB)
-Waiver ICF/MR (W-MR)
-Medicare Dual Eligible

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only QMB

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare

ADDITIONAL INFORMATION

Enrollment is mandatory for children that are categorized as blind or disabled.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)

Use of Collected Data:

-Contract Standard Compliance

- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Field Audits
- -Monitoring of PAHP Standards
- -On-Site Reviews
- -PAHP Standards
- -Provider Data

- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
None

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
-Subcontractors must be audited and approved before beginning service

SOUTH DAKOTA
PRIME

CONTACT INFORMATION

State Medicaid Contact:	Angie Bren Office of Medical Services (605) 773-3495
State Website Address:	http://www.state.sd.us/Social/Medicaid/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Laboratory, Opthalmology, Outpatient Hospital, Outpatient Mental Health, Physician, Residential Treatment Centers, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children (BBA defined)

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Provider contacts - Medically fragile protocol
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PRIME

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data

Use of Collected Data:
-Beneficiary Provider Selection

SOUTH DAKOTA
PRIME

-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

Consumer Self-Report Data:
-Disenrollment Survey
-State-developed Survey

Performance Measures

Process Quality:
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Diabetes management
-Pre-natal care

Non-Clinical Topics:
None

WASHINGTON
Healthy Options

CONTACT INFORMATION

State Medicaid Contact:

Peggy Wilson
Division of Program Support, DSHS-HRSA
(360) 725-1731

State Website Address:

http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 2002

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
-AI/AN Children Below 200 Percent of FPL
-AI/AN Title XXI SCHIP
-AI/AN Section 1931 (TANF Related) Children
-AI/AN Section 1931 (TANF Related) Adults
-AI/AN Poverty Level Pregnant Women
-American Indian/Alaskan Native (AI/AN)

Populations Mandatorily Enrolled:
None

WASHINGTON
Healthy Options

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Retroactive Eligibility
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligibles

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

WASHINGTON
Healthy Options

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Retroactive Eligibility
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Foster Care/Adoption Support Children Programs
-Aged, Blind and Disabled SSI Related Programs

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women and Optional Children

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

WASHINGTON
Healthy Options

Strategies Used to Identify Persons with Complex (Special) Needs:

-Obtains an electronic listing from Department of Health, a separate agency
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Asuris Northwest Health
Community Health Plans
Kaiser Foundation Health Plan
PCCM Tribal Clinics
Regence Blue Shield
Columbia United Providers
Group Health
Molina
PCCM Tribal Clinics

ADDITIONAL INFORMATION

Children with Special Health Care Needs are defined as children identified by DSHS to the contractor as children served under provisions of Title V of the Social Security Act.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Provided data submission requirements including

documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of Medicaid Identification Number for beneficiaries
-Use of Medicaid Provider Identification Numbers for providers

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Immunization Rates
-Monitor Well Child Visits

Access/Availability of Care:
-Prenatal/postpartum measures

Use of Services/Utilization:
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Coronary artery disease prevention

-Depression management
-Diabetes management
-Emergency Room service utilization
-Hypertension management
-Well Child Care/EPSDT

Non-Clinical Topics:
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Acumentra (formerly known as OMPRO)

EQRO Mandatory Activities:
-On site visits
-Review of Managed Care Quality Plan
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data

Consumer Self-Report Data:
-CAHPS
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of Collected Data:
None

WASHINGTON
Medicare/Medicaid Integration Partnership (MMIP)

CONTACT INFORMATION

State Medicaid Contact:

Alice Lind
Health and Recovery Services Administration
(360) 725-1629

State Website Address:

http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Long Term Care, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Internists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

WASHINGTON
Medicare/Medicaid Integration Partnership (MMIP)

Subpopulations Excluded from Otherwise Included Populations:
-TANF
-Poverty Level Pregnant Woman
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Benzodiazepines
-Nonprescription drugs

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Evercare Premier

ADDITIONAL INFORMATION

The state contracts with Evercare Premier to provide an integrated managed care program that covers a full scope of medical services and long term care services. The program includes an intensive care management component to assist enrollees with multiple health needs to access needed services.

QUALITY ACTIVITIES FOR MCO/HIO

WASHINGTON
Medicare/Medicaid Integration Partnership (MMIP)

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Medical Reviews

Consumer Self-Report Data:
-Medicare CAHPs

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Required use of Medicaid Provider Identification numbers for service providers
-Use of Provider Identification Numbers for providers

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:
Yes

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

EQRO Name:
-Acumentra formerly known as OMPRO

WASHINGTON

Medicare/Medicaid Integration Partnership (MMIP)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance measures

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

CONTACT INFORMATION

State Medicaid Contact:

Alice Lind
Health and Recovery Services Administration
(360) 725-1629

State Website Address:

http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

WASHINGTON

Washington Medicaid Integration Partnership (WMIP)

Subpopulations Excluded from Otherwise Included Populations:
- -Poverty Level Pregnant Woman
- -Special Needs Children (State defined)
- -Special Needs Children (BBA defined)
- -Medicare Dual Eligibles
- -TANF

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- -Benzodiazepines
- -Nonprescription drugs

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Aging Agency
- -Developmental Disabilities Agency
- -Housing Agencies
- -Mental Health Agency
- -Public Health Agency
- -Social Services Agencies
- -Substance Abuse Agency
- -Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Molina

ADDITIONAL INFORMATION

The state contracts with Molina Healthcare of Washington to provide an integrated managed care program that covers a full scope of medical services, inpatient, and outpatient mental health and chemical dependency services. The program includes an intensive care management component to assist enrollees with multiple health needs to access needed services.

QUALITY ACTIVITIES FOR MCO/HIO

WASHINGTON

Washington Medicaid Integration Partnership (WMIP)

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Medical Reviews
-Performance Measures (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire with Suplemental Questions

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Required use of Medicaid Provider Identification numbers for service providers
-Use of Provider Identification Numbers for providers

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

None

Health Status/Outcomes Quality:

None

WASHINGTON

Washington Medicaid Integration Partnership (WMIP)

Access/Availability of Care:
-Access and Maintenance for Mental Health
-Screening, Access and Treatement for Chemical Dependency

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Acumentra formerly known as OMPRO

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance measures

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

WISCONSIN
Medicaid HMO Program

CONTACT INFORMATION

State Medicaid Contact:	Jason Helgerson Division of Health Care Financing (608) 266-8922
State Website Address:	http://dhfs.wisconsin.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 31, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Poverty-Level Pregnant Women

WISCONSIN
Medicaid HMO Program

Subpopulations Excluded from Otherwise Included Populations:
- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -American Indian/Alaskan Native
- -Residents residing in FFS counties
- -Migrant workers
- -Special Needs Children (BBA defined)
- -Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Reviews complaints and grievances to identify members of these groups
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Maternal and Child Health Agency (County departments)
- -Mental Health Agency (County departments)
- -Public Health Agency (County departments)
- -Social Services Agency (County departments)
- -Substance Abuse Agency (County departments)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Abri Health Plan -- Medicaid HMO
Compcare (formerly Atrium Health Plan) -- Medicaid HMO
Group Health Cooperative Of Eau Claire -- Medicaid HMO
Health Tradition Health Plan -- Medicaid HMO
MercyCare Insurance Company -- Medicaid HMO
Security Health Plan -- Medicaid HMO
Unity Health Insurance -- Medicaid HMO
Children's Community Health Plan - Medicaid
Dean Health Plan -- Medicaid HMO
Group Health Cooperative Of South Central WI -- Medicaid HMO
Managed Health Services -- Medicaid HMO
Network Health Plan -- Medicaid HMO
UnitedHealthcare of WI -- Medicaid HMO

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Satisfaction Survey
-External Quality Review
-MCO Standards
-MHO Report Care
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Non-Duplication of mandatory EQR Activities Base on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Quality Improvement Goal Setting

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

State conducts general data completeness assessments:

Yes

WISCONSIN
Medicaid HMO Program

- -Medicaid Eligibility
- -Plan Enrollment
- -Diagnosis Codes
- -Procedure Codes
- -Revenue Codes
- -Age-appropriate diagnosis/procedure
- -Gender-appropriate diagnosis/procedure
- -Admission source
- -Admission type
- -Days supply
- -Modifier codes
- -Patient status code
- -Place of service codes
- -Quantity

Performance Measures

Process Quality:

- -Breast Cancer screening rate
- -Cervical cancer screening rate
- -Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years, 6-14 years, and 15-20 years
- -Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14years and 15-20 years
- -Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5, 6 and 7 or more visits
- -Dental services
- -Diabetes management
- -Follow-up after hospitalization for mental illness
- -Hearing services for individuals of all ages
- -Immunizations for two year olds
- -Lead screening rate
- -Percentage of beneficiaries who are satisfied with their ability to obtain care
- -Percentage of beneficiaries with at least one dental visit
- -Vision services for individuals of all ages

Health Status/Outcomes Quality:

- -Breast malignancies detected
- -Cervix/uterus malignancies detected
- -HPV infections detected
- -Patient satisfaction with care

Access/Availability of Care:

- -Average distance to PCP
- -Provider network data on geographic distribution
- -Ratio of mental health providers to number of beneficiaries
- -Ratio of PCPs to beneficiaries

Use of Services/Utilization:

- -Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
- -Percent of beneficiaries with at least one PCP visit
- -Percent of beneficiaries with at least one specialist visit
- -Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:

None

Health Plan/ Provider Characteristics:

- -Board Certification
- -Languages Spoken (other than English)

Beneficiary Characteristics:

None

Performance Improvement Projects

Project Requirements:

- -MCOs are required to conduct a project(s) of their own choosing
- -Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

- -Adolescent Immunization
- -Antibiotic Resistance
- -Asthma management
- -Breast cancer screening (Mammography)

-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Improving Birth Outcome Project
-Lead toxicity
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC (previously known as Utilization Review Accreditation Committee) Standards

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-MetaStar

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Well-child visits

Initial Year of Reward:
1996

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Delivery of EPSDT Services

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

WISCONSIN

Medicaid SSI Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Jason Helgerson
Division of Health Care Financing
(608) 266-8922

State Website Address:

http://dhfs.wisconsin.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Coordination With Non-Medicaid Services (Social & Vocational Services), Recreational & Wellness Prog, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pediatricians, Personal Care, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles
-American Indians

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations

WISCONSIN
Medicaid SSI Managed Care Program

Subpopulations Excluded from Otherwise Included Populations:

-Beneficiaries Who After Enrollment Are Placed In A Nursing Home For Longer Than 90 Days
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Children Under Age 19
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-None - managed care entity provides standard prescription drug coverage

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Comprehensive Assessment Required At Time of Enrollment
-Only SSI-Disabled Adult Recipients May Enroll
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Local Public Health Agency
-Mental Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Abri Health Plan -- SSI
Independent Care Health Plan -- SSI
Network Health Plan - SSI
Health Advantage -- CLA
Managed Health Services -- SSI
UnitedHealthcare of WI -- SSI

ADDITIONAL INFORMATION

SSI Managed Care Program is for SSI and SSI-related Medicaid recipients, age 19 or older not living in an institution and not participating in a home and community based waiver. Dually eligible persons and Medicaid Purchase Plan recipients may enroll on a voluntary basis. Targeted Case Management Community Support Program Services, and Crisis Intervention Services are covered under fee-for-service for enrollees in this program.1

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

State conducts general data completeness assessments:

Yes

-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

Performance Measures

Process Quality:

-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness and substance abuse at 7 and 30 days
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality:

-Patient satisfaction with care

Access/Availability of Care:

-Monitoring Disenrollments
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Asthma prevalence, ED care and inpatient care
-Inpatient general and speciality care: surgery, medical, psychiatry, substance abuse
-Mental health/substance abuse evaluations and day and outpatient care
-Outpatient general and specialty care: ED without admit, primary care visits, vision care, audiology, general dental
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:

None

Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:

-Beneficiary need for interpreter
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:

-Adolescent Immunization
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Flu Vaccine Rate
-Lipid Screening

Non-Clinical Topics:

-Access to and availability of services
-Cultural competency of the HMO and its providers
-Enrollee satisfaction with the HMO customer service
-Grievances, appeals and complaints

-Satisfaction with services for enrollees with special health care needs

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-MetaStar

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

Section:
1915(a) - Voluntary Programs

This page was not included in the page numbering

ALABAMA

Partnership Hospital Program

CONTACT INFORMATION

State Medicaid Contact:

Jerri Jackson
Alabama Medicaid Agency
(334) 242-5630

State Website Address:

http://www.medicaid.alabama.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority/Section 1902(a)(4)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Inpatient Hospital

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman

Lock-In Provision:
Does not apply because State only contracts with one

-Aliens
-Plan First (FP Waiver) eligibles
-Foster Care Children
-Medicare Dual Eligibles
-Department of Youth Services (DYS) eligibles

managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Partnership Hospital Program

ADDITIONAL INFORMATION

Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operations of a State Medicaid plan. The application of the requirements of this part to PIHPs that do not meet the statutory definition of MCO or to a PCCM is under the authority in Section 1902(a)(4).

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Use of Collected Data:
-Monitor Quality Improvement
-Track Health Service provision

ALABAMA

Partnership Hospital Program

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality:
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Coding Errors

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
None

Non-Clinical Topics:
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Alabama Quality Assurance Foundation

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

CALIFORNIA
AIDS Healthcare Foundation

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Laboratory, Long Term Care, Outpatient Hospital, Pharmacy, Physician, Specialty Mental Health, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Section 1931 (AFDC/TANF) Children and Related

Populations Mandatorily Enrolled:
None

CALIFORNIA
AIDS Healthcare Foundation

Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Poverty Level Pregnant Woman
-Member approved for a Major Organ Transplant
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for anorexia, weight loss, weight gain
-Agents when used for cosmetic purposes or hair growth
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Drugs used to promote fertility
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Plan is responsible to identify this group

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Positive Healthcare/AHF Healthcare Centers

ADDITIONAL INFORMATION

PCPs contract to provide and assume risk for primary care, specialty physician services, and selected outpatient preventive and treatment services. The Program is designed for people living with AIDS. Program changed from a PCCM program to MCO(Managed Care Organization). All categories of federally eligible Medi-Cal are eligible to participate.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
-Not Applicable

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand

Health Plan/ Provider Characteristics:
None

-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Not Applicable

Accreditation Required for Participation:
None

EQRO Name:
-Not Applicable

EQRO Mandatory Activities:
-Not Applicable

EQRO Optional Activities:
-Not Applicable

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

CALIFORNIA

Family Mosaic

CONTACT INFORMATION

State Medicaid Contact:	Vanessa Baird Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Emotional and Mental Health Support PIHP - Risk-based Capitation

Service Delivery

Included Services:
Emotional Support, Inpatient Mental Health, Mental Health Support

Contractor Types:
None

Allowable PCPs:
-N/A

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

-Medicare Dual Eligibles
-Populations residing outside plans service area defined by contract

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Plan is responsible to identify this group

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

San Francisco City & CO/Family Mosiac

ADDITIONAL INFORMATION

San Francisco City and County/Family Mosaic only provides emotional and mental support to severely emotionally distrubed children.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Performance Measures

Process Quality:
None

Access/Availability of Care:
None

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
None

Standards/Accreditation

PIHP Standards:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Not Applicable

Accreditation Required for Participation:
None

EQRO Name:
-Not Applicable

EQRO Mandatory Activities:
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA
Prepaid Health Plan Program

CONTACT INFORMATION

State Medicaid Contact:

Vanessa Baird
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
HCO

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1972

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Other Insurance
-Participate in HCBS Waiver
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR (after 30 days)

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for cosmetic purposes or hair growth
-Agents when used for symptomatic relief of cough and colds
-Agents when used to promote fertility
-Barbituates
-Benzodiazepines
-Drugs used to promote fertility
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Populations residing outside plans service area defined by contract

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

CALIFORNIA
Prepaid Health Plan Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-LA
Kaiser Foundation (North)
UHP Healthcare-Dental
Western Dental Services-LA
American Health Guard-Dental Plan-LA
Safeguard Dental Inc.
Universal Care-Dental-LA

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
-Not Applicable

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality:
None

Access/Availability of Care:
None

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
None

Standards/Accreditation

MCO Standards:
None

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

EQRO Name:
-Not Applicable

CALIFORNIA
Prepaid Health Plan Program

EQRO Organization:
-Not Applicable

EQRO Mandatory Activities:
-Not Applicable

EQRO Optional Activities:
-Not Applicable

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Does not collect quality data.

Use of Collected Data:
-Not Applicable

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

COLORADO
Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Jerry Smallwood
Dept. of Health Care Policy and Financing
(303) 866-5947

State Website Address:

http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS, INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1983

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Participate in HCBS Waiver
-Medicare Dual Eligibles

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

QMB
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Medical-only PIHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Colorado Access
Rocky Mountain Health Plan Authority
Denver Health and Hospital Authority

ADDITIONAL INFORMATION

Program was converted from a 1915(b) to a 1915(a) on May 1, 2003. MCO options and PIHP options are available and varies by county.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Medical record validation

care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Revenue Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Medical loss ratio
-Net income
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:

-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:

-Diabetes management

Non-Clinical Topics:

-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Health Services Advisory Group, Inc.

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

COLORADO

Managed Care Program

Health Plan Stability/ Financial/Cost of Care:
-Medical loss ratio
-Net income
-State minimum reserve requirements

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-PIHP/PCP-specific disenrollment rate

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements:

-Multiple, but not all, PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:

-Children's access to primary care practitioners

Clinical Topics:

-Diabetes management

Standards/Accreditation

PIHP Standards:
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Health Services Advisory Group. Inc.

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

DISTRICT OF COLUMBIA
Health Services for Children with Special Needs

CONTACT INFORMATION

State Medicaid Contact:	Maude Holt Dept. of Health, Medical Assistance Administrator (202) 724-7491
State Website Address:	http://www.dchealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
HOUSTONS INC

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Services For Children with Special Needs

ADDITIONAL INFORMATION

This is no longer a demonstration program but a cost-base reimbursement program and there is no risk involved for providers. Program provides Emergency Transportation only and Skilled Nursing Facility for first 30 days. Special Needs Children (State-defined): Those children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by children generally. This definition includes children on SSI or who are SSI-related eligibles.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Consumer Self-Report Data:

None

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Diabetes medication management
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
None

Standards/Accreditation

PIHP Standards:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

ILLINOIS

Voluntary Managed Care

CONTACT INFORMATION

State Medicaid Contact:

Laura Ray
Illinois Department of Healthcare and Family Services
(217) 524-7478

State Website Address:

http://www.hfs.illinois.gov/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
November 01, 1974

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Assistive/Augmentative Communication Devices, Audiology Services, Behavioral Health, Blood and Blood Components, Case Management, Chiropractic, Clinic, Diagnosis and treatment of medical conditions of the eye, Disease Management, Durable Medical Equipment, Emergency Services, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Psychiatric Care, Inpatient Substance Use Disorders, Laboratory, Medical procedures performed by a dentist, Non-Durable Medical Equipment and Supplies, Nurse Midwives, Occupational Therapy, Orthotic/Prosthetic Devices, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Psychiatric Care, Skilled Nursing Facility, Speech Therapy, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

ILLINOIS
Voluntary Managed Care

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:
-Spenddown Eligibles
-Other Insurance - High Level
-Age 19 or older and eligible thru State Family and Children Assistance Program
-Medicaid Presumptive Eligibility for Pregnant Women
-Non-citizens only receiving emergency services
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Illinois Inc.
Harmony Health Plan
Family Health Network

ADDITIONAL INFORMATION

Nursing facility services are provided up to 90 days annually.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Modified CAHPS Survey

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

State conducts general data completeness assessments:
Yes

-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:

-Access/Availability of Care: Prenatal and Postpartum Care
-Adolescent well-care visit rates
-Asthma care- medication use
-Births and average length of stay, newborns
-Breast Cancer Screening Rate
-Cervical Cancer Screening Rate
-Check-ups after delivery
-Chlamydia screening in women
-Controlling high blood pressure
-Depression management/care
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Health history/physicals
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:

-Chemical Dependency Utilization and use of services
-Patient satisfaction with care
-Percentage of low birth weight infants
-Percentage of very low birth weight infants

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:

-Admitting and delivery privileges
-Languages Spoken (other than English)
-Provider license number
-Specialty of providers

Beneficiary Characteristics:

-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:

-EPSDT/Content of care for under age three
-Prenatal Depression Screening

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-External Quality Review Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Health Services Advisory Group
-HealthSystems of Illinois

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities
-validate performance improvement project - over-read sample

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

MINNESOTA

Minnesota Disability Health Options (MnDHO)

CONTACT INFORMATION

State Medicaid Contact:	Christine Bronson Minnesota Department of Human Services (651) 282-9921
State Website Address:	http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2001

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home and Community-Based Waiver, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

MINNESOTA

Minnesota Disability Health Options (MnDHO)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Reside in Regional Treatment Center
-QMB or SLMB, Not Otherwise Eligible for Medicaid
-Eligible for Medicare Part A or Part B Only

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

UCARE

ADDITIONAL INFORMATION

PCP provider types are designated by HMOs rather than State. Health plans have been encouraged to develop networks with professionals with disability experience. Skilled Nursing Facility is covered up to 180 days. All medicare services under parts A, B, and D are included.

QUALITY ACTIVITIES FOR MCO/HIO

MINNESOTA
Minnesota Disability Health Options (MnDHO)

State Quality Assessment and Improvement Activities:
-Annual HCBS Quality Assurance Plan
-Care Plan Audits
-Care System Reviews
-Community Measurement Project
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid Questionaire
-Disenrollment Survey

Use of Collected Data:
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO

State conducts general data completeness assessments:
Yes

-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:
-Care Plan Audit
-Influenza vaccination rate

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to PCP
-Number of PCP Ambulatory Visits

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Use of Home Health Care/1000 Beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Prevention of Influenza and Pneumonia

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:
-Performance Improvement Projects

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-FMAS (QIO-like)
-MetaStar (QIO)
-Michigan PRO
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Organization:
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

MINNESOTA

Minnesota Senior Health Options Program (MSHO)

CONTACT INFORMATION

State Medicaid Contact:

Christine Bronson
Minnesota Department of Human Services
(651) 431-2914

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Services Available Under The Home And Community-Based Waiver, Skilled Nursing Facility, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Age 65 or Older and Dually Eligible for Medicare and Medicaid, or Eligible for Medicaid without Medicare
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Other Insurance
-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Mental Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
PrimeWest Health System
UCARE
First Plan Blue
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

ADDITIONAL INFORMATION

PCP provider types are designated by HMOs rather than State; county staff perform enrollment functions. Health plans have been encouraged to develop networks with professionals with geriatric experience. All medicare services under parts A, B, and D are included. Skilled nursing facility services are covered for up to 180 days.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Annual HCBS Quality Assurance Plan
-Care Plan Audits
-Care System Reviews
-Community Measurement Project
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-HCBS Self-Assessment QA Survey
-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid Questionaire
-Disenrollment Survey
-State-Developed Survey for Nursing Home Enrollees/Families

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Limited automated analysis of encounter data submissions to help determine data completeness
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing

State conducts general data completeness assessments:

Yes

-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:
-Care Plan Audits
-Cholesterol screening and management
-Diabetes management/care
-Influenza Vaccination Rate
-Timeliness of HCBS Reassessments
-Use of Home and Community-Based Services
-Use of Nursing Home Days

Health Status/Outcomes Quality:
-Family Satisfaction with Care - Nursing Home Members
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to PCP
-Number of PCP Ambulatory Visits

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Use of Home Health Care/1000 Beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Calcium/Vitamin D
-Congestive Heart Failure Management
-Diabetes management/care
-Optimal Medication Management
-Prevention of Influenza and Pneumonia

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:
-BBA Managed Care Standards
-CMS's PIP Requirements

Accreditation Required for Participation:
None

MINNESOTA

Minnesota Senior Health Options Program (MSHO)

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Name:
-MetaStar (QIO)
-Michigan PRO (QIO)
-Stratis Health (QIO)

EQRO Mandatory Activities:
-Validation of performance measures

EQRO Optional Activities:
-Special Federal Projects on Dual Medicare-Medicaid Eligibles

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Clinical Conditions:
Dental

Initial Year of Reward:
1999

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

MISSISSIPPI
Disease Management Program

CONTACT INFORMATION

State Medicaid Contact:

Alicia Crowder
Mississippi Medicaid Agency
(601) 359-5243

State Website Address:

www.dom.state.ms.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority/Section 1902(a)(4)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 15, 2003

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Registered Nurses

Enrollment

Populations Voluntarily Enrolled:
-Persons having one or more of the following diseases: Asthma, Diabetes, and/or Hypertension
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Hospice
-Participate in LTC Facility
-Reside in Nursing Facility or ICF/MR

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

-Family Planning Waiver
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Claims data

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson

ADDITIONAL INFORMATION

The State contracts with McKesson to provide enrollment, assessment, interventions, and physican reporting services to target beneficiaries with one or more of the following diseases: asthma, hypertension, and diabetes. Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operations of a State Medicaid plan. The application of the requirements of this part to PAHPs that do not meet the statutory definition of MCO or to a PCCM is under the authority in Section 1902(a)(4).

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Enrollee Hotlines
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the

HEDiS measure listed for Medicaid

Performance Measures

Process Quality:
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes management/care
-Diabetes medication management
-Heart failure care
-Influenza vaccinationa rate
-Smoking prevention and cessation

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient Hospital stays

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:

-PAHPs are required to conduct a project(s) of their own choosing

Clinical Topics:

None

Non-Clinical Topics:

Not Applicable - PAHPs are not required to conduct common project(s)

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

NEW YORK
Managed Long Term Care Program

CONTACT INFORMATION

State Medicaid Contact:

Linda Gowdy
Office of Managed Care, NY State Dept. of Health
(518) 474-6965

State Website Address:

www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Long Term Care PIHP (risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Meals, Medical Social Services, Nutrition, Occupational Therapy, Personal Care, Personal Emergency Response System, Physical Therapy, Podiatry, Private Duty Nursing, Respiratory Therapy, Skilled Nursing Facility, Speech Pathology, Transportation, Vision

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles

Lock-In Provision:

1 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

CarePlus Connections
Health Advantage/Elant Choice
HomeFirst
Long Island Health Partners/Broadlawn Health Partners
Partners In Community Care
Total Aging in Place
Guildnet
Hebrew Hospital Home/CO-OP Care Plan
Independent Care Systems
Mohawk Valley Network/Senior Network Health
Senior Health Partners
VNS Choice

ADDITIONAL INFORMATION

To be eligible for this program, a person must have a disability or chronic illness and must be in a nursing home. Beneficiaries may receive services at home or in a Nursing Home in the plan network.

QUALITY ACTIVITIES FOR PIHP

NEW YORK
Managed Long Term Care Program

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
-Contract Standard Compliance
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms:
None

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Provider networks and updates are collected quarterly and reviewed for accuracy

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

Beneficiary Characteristics:
-Upon enrollment DMS-1 assessment score that measures

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
-Drug Utilization
-Number of home health visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

nursing home eligibility

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:

None

Non-Clinical Topics:

Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards:

-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:

None

EQRO Organization:

-Quality Improvement Organization (QIO)

Accreditation Required for Participation:

None

EQRO Name:

-IPRO - Island Peer Review Organization

EQRO Mandatory Activities:

-Validation of performance improvement projects

EQRO Optional Activities

-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

-Technical assistance to PIHPs to assist them in conducting quality activities

NEW YORK
Office of Mental Health/Partial Capitation Program

CONTACT INFORMATION

State Medicaid Contact:	Joe Kaiser New York State Office of Mental Health (518) 473-9582
State Website Address:	http://www.omh.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PAHP - Risk-based Capitation

Service Delivery

Included Services:
Mental Health Continuion Day Treatment, Mental Health Intensive Psychiatric Rehabilitation Treatment, Mental Health Outpatient

Contractor Types:
-New York State Office of Mental Health Hospital

Allowable PCPs:
-Mental Health PCP
-Personal Services Coordinator

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Receiving outpatient (Clinic, CDT, IPRT)
-Admitted to an outpatient psychiatric center program
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

NEW YORK
Office of Mental Health/Partial Capitation Program

Subpopulations Excluded from Otherwise Included Populations:
-Participation in HCBS Waiver
-Special Needs Children (BBA defined)
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Eligibility Period Less Than 6 Months

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OMH/Partial Capitation

ADDITIONAL INFORMATION

The patients are referred by their hospitals or outpatient programs for mental health services.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-PAHP Standards
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation

-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Number of encounters per provider

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Use of acute sector hospitalization

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Non-Duplication Based on Accreditation:
None

PENNSYLVANIA
Long Term Care Capitated Assistance Program (PIHP)

CONTACT INFORMATION

State Medicaid Contact:	James Pezzuti PA Department of Public Welfare (717) 772-2525
State Website Address:	www.state.pa.us

PROGRAM DATA

Program Service Area:
County
Zip Code

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Hearing, Hospice, Immunization, In-home Supportive Care, Institutional, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

PENNSYLVANIA
Long Term Care Capitated Assistance Program (PIHP)

Subpopulations Excluded from Otherwise Included Populations:
- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LIFE - Beaver County
LIFE - Geisinger
LIFE - Geisinger
Senior LIFE Johnstown

ADDITIONAL INFORMATION

The two pre-PACE sites listed are identified as Medical-only PIHP. Program provides capitated institutional services not capitated inpatient hospital services.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
- -Monitoring of PIHP Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -PIHP Standards

Consumer Self-Report Data:
None

Use of Collected Data:
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality:
None

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:
None

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics:
Not Applicable - PIHPs are not required to conduct common project(s)

Clinical Topics:
None

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-IPRO

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities

PENNSYLVANIA
Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact:	Patricia Jacobs Pennsylvania Department of Welfare (717) 772-6300
State Website Address:	http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Affiliated Computer Services (ACS), LLC

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1972

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners
-Pediatricians
-General Practitioners

Enrollment

Populations Voluntarily Enrolled:
-State Only Categorically Needy
-State Only Medically Needy

Populations Mandatorily Enrolled:
None

- -Pregnant Women
- -Special Needs Children (State defined)
- -Medicare Dual Eligibles
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

- -State Blind Pension Recipients
- -Monthly Spend Downs
- -Reside in Nursing Facility or ICF/MR
- -Medicare Dual Eligibles
- -Enrolled in Another Managed Care Program
- -Residence in a State Facility
- -Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
- -Enrolled in Long Term Care Capitated Program (LTCCP)
- -Incarceration

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Medicare Under 21

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-None - managed care entity provides standard prescription drug coverage

Provides Part D Benefits:
Yes

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Asks advocacy groups to identify members of these groups
- -Uses eligibility data to identify members of these groups
- -Uses enrollment forms to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Aging Agency
- -Education Agency
- -Housing Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency
- -Social Services Agency
- -Substance Abuse Agency
- -Transportation Agency

PENNSYLVANIA
Voluntary HMO Contracts

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan - VOL

Unison Health Plan

UPMC Health Plan, Inc./UPMC for You - VOL

Gateway Health Plan, Inc. -VOL

Unison Health Plan/MedPlus - VOL

ADDITIONAL INFORMATION

Included Services: Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, and Outpatient Substance Use Disorders are provided on a Fee-For-Service basis or through Behaviorial Health MCOs where implemented. Special Needs Children: (state defined) Broadly defined non-categorical to include all children. Skilled Nursing Facility is provided for the first 30 days. Transportation services only includes emergency ambulance services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:

-CAHPS
    3.0H Adult and Children
-Plan-developed survey

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Use of HEDIS:

-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:

-Patient satisfaction with care

-Well-child care visit rates in 7, 9 or 11 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Use of Services/Utilization:
-All use of services in HEDIS measures
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:

-Adults Access to Dental Care
-Childrens Access to Dental Care

Clinical Topics:

-Adolescent Pregnancy
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Hypertension management
-Smoking prevention and cessation

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

PENNSYLVANIA
Voluntary HMO Contracts

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-IPRO

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Asthma
Breast Cancer Screening
Cardiac Care
Cervical Cancer Screening
Diabetes
Prenatal Care

Initial Year of Reward:
2006

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

PUERTO RICO
Medicare Platino

CONTACT INFORMATION

State Medicaid Contact:

Wendy Matos-Negron
PR Department of Health
(787) 250-0453

State Website Address:

http://www.ases.gobierno.pr

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulance, Ambulatory Surgery, Dental, Diagnosis and Treatment of tuberculosis and leprosy, EPSDT, Family Planning, Immunization, Inpatient Hospital, Inpatient Mental Health, Maternity Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Exam, Physician, Transportation, Vision

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-All populations who are not dual eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

PUERTO RICO
Medicare Platino

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Barbituates
-Benzodiazepines
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Health Medicare
COSVIMed
Humana Puerto Rico
MCS Life
PMC Medicare Choice
Auxilio Platino
First Medical Health Plans
MAPFRE Puerto Rico
MMM Healthcare Inc.
Triple S

ADDITIONAL INFORMATION

Medicare Platino is a program contracted with Medicare Advantage Plans to provide coverage to qualified beneficiaries from the Puerto Rico Health Care Program. Medicare Platino provides Medicaid wrap services that are not provided by the Medicare Advantage Plans to ensure the same level of service and coverage as in the Puerto Rico's Health Care Program. Program is strictly for dual eligibles.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance

PUERTO RICO
Medicare Platino

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Pregnancy Prevention
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Number of children with diagnosis of rubella(measles)/1,000 children

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

PUERTO RICO
Medicare Platino

Health Plan Stability/ Financial/Cost of Care:
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Total revenue

Beneficiary Characteristics:
None

Health Plan/ Provider Characteristics:
-Board Certification

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
None

Clinical Topics:
-Asthma management
-Diabetes management
-Hypertension management

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Quality Improvement Professional Research Organization

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

PUERTO RICO

Puerto Rico Health Care Plan

CONTACT INFORMATION

State Medicaid Contact:	Wendy Matos-Negron, PhD PR Department of Health (787) 250-0453
State Website Address:	http://www.ases.gobierno.pr

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

- -Foster Care Children
- -TITLE XXI SCHIP
- -Individual/Families up to 200% of Puerto Rico poverty level
- -Police
- -Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

- -Barbituates
- -Benzodiazepines
- -Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

PUERTO RICO
Puerto Rico Health Care Plan

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation

Allowable PCPs:
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:
-Individual/families up to 200% of the Puerto Rico poverty line
-Police
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Foster Care Children

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Barbituates
-Benzodiazepines
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

PUERTO RICO
Puerto Rico Health Care Plan

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alianza de Medicos de Sur Este, Inc.
FHC Healthcare
MCS Health Management Options, Inc.
Triple-S, Inc.
APS Healthcare
Humana Health Plans of Puerto Rico, Inc.
San Judas Medical Services

ADDITIONAL INFORMATION

Puerto Rico's Health Care Program is not a voluntary program. It is a mandatory managed care program which requires no waiver authority because Puerto Rico is statutory exempt from Freedom of Choice requirements. PRHIA main duty is to obtain health insurance coverage for the medically indigent. Vision and hearing services are only included under physician services and other ancillary services. Mental Health and Abuse program is separated and handled by MBHOs. There are no QMBs dual eligibles in Puerto Rico.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
-Contract Standard Compliance

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms:
None

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Pregnancy Prevention
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Number of children with diagnosis of rubella(measles)/1,000 children

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:
-Asthma management
-Emergency Room service utilization

Non-Clinical Topics:
-Call Center (Triage Access)
-Enrollee Information System

PUERTO RICO
Puerto Rico Health Care Plan

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Quality Improvement Professional Research Organization

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Monitoring of PIHP Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
None

PUERTO RICO

Puerto Rico Health Care Plan

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Health Plan Stability/ Financial/Cost of Care:
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Total revenue

Beneficiary Characteristics:
None

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
-Board Certification

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics:

Not Applicable - PIHPs are not required to conduct common project(s)

Clinical Topics:

None

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Other University

Accreditation Required for Participation:
None

EQRO Name:
-Medical Science Campus (MSC) - University of Puerto Rico Behavioral Science Research Institute

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities

SOUTH CAROLINA
Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact:

Beverly Hamilton
Division of Care Management
(803) 898-4502

State Website Address:

http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
August 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Alcohol and Drug Screening, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Interactive Psychiatric Interview Exam with other Mechanisms of Communication, Laboratory, Outpatient Hospital, Pharmacy, Physical Exam through the SC Department of Alcohol and other Drug Abuse Services, Physician, Psychiatric Diagnostic Interview Exam, Skilled Nursing Facility, Transportation, X-Ray

Allowable PCPs:
-Rural Health Centers (RHCs)
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Age 65 Or Older
-Hospice Recipients
-Enrolled In An HMO Through Third Party Coverage
-Medically Fragile Children Program

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Select Health of South Carolina, Incorporated (HMO)

Unison Health Plan of SC (HMO)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

SOUTH CAROLINA

Health Maintenance Organization (HMO)

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards
-Monitoring of MCO Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:

None

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:

-NSF (National Standard Format)
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Date of Admission Invalid
-Date of Discharge Invalid
-Dollar amount billed not greater than zero
-Drug Quantity Units not greater than zero
-Invalid Drug Unit Type
-Prescribing Provider Number Not on File

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments:

Yes

-Submitting Provider Not on File

Performance Measures

Process Quality:
-Asthma care - medication use
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-(Newborn) Failure to thrive
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Childhood Immunization
-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Pharmacy management
-Post-natal Care
-Pregnancy Prevention
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

SOUTH CAROLINA

Health Maintenance Organization (HMO)

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Carolina Medical Review

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Conduct performance improvement projects
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

SOUTH CAROLINA
Medically Fragile Children Program (MFCP)

CONTACT INFORMATION

State Medicaid Contact:	Bruce Harbaugh South Carolina Department of Health and Human Services (803) 898-2618
State Website Address:	www.scdhhs.gov

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency Room, Family Planning, Hearing, Home Health, Immunization, Occupational Therapy, Outpatient Hospital, Personal Care, Pharmacy, Physician, Primary Care, Psychological Services, PT/OT, Respiratory Therapy, Speech Therapy, Transportation, Vision

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Special Needs Children (State defined)
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:
None

SOUTH CAROLINA
Medically Fragile Children Program (MFCP)

Subpopulations Excluded from Otherwise Included Populations:
- -Medicare Dual Eligibles
- -Poverty Level Pregnant Woman
- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Maternal and Child Health Agency
- -Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medically Fragile Children

ADDITIONAL INFORMATION

The target population is made up of children whose medical conditions and functional impairments result in a complexity of care that requires a system capable of providing intensive, individualized, coordinated interventions in a manner that is timely, effective and cost efficient. (The population characteristics were utilized in the processes employed to compute the capitated rate.)

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- -Accreditation for Participation (see below for details)
- -Encounter Data (see below for details)
- -Focused Studies
- -Network Data

Use of Collected Data:
- -Fraud and Abuse
- -Program Evaluation
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

-On-Site Reviews
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PAHPs

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

Access/Availability of Care:
-None

Use of Services/Utilization:
-None

SOUTH CAROLINA
Medically Fragile Children Program (MFCP)

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-None

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Non-Duplication Based on Accreditation:
None

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

CONTACT INFORMATION

State Medicaid Contact:	Christopher Lykes Department of Physician Services (803) 898-2547
State Website Address:	http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PAHP (risk or non-risk, non-comprehensive) - Physician Services Capitation

Service Delivery

Included Services:
Emergency Room, EPSDT, Family Planning, Immunization, Laboratory, Physician, Preventive Health Exams, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physicians Enhanced Program (PEP)

ADDITIONAL INFORMATION

Only physician services are capitated for this program. All other services are fee-for-service.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Not Applicable

Consumer Self-Report Data:
None

Use of Collected Data:
-Not Applicable

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None

SOUTH DAKOTA

Dental Program

CONTACT INFORMATION

State Medicaid Contact:

Angie Bren
Office of Medical Services
(605) 773-3495

State Website Address:

http://www.state.sd.us/social/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-Poverty-Level Pregnant Women
-Foster Care Children

Populations Mandatorily Enrolled:
None

SOUTH DAKOTA
Dental Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only QMB

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delta Dental

ADDITIONAL INFORMATION

Most of the Medicaid eligibles are automatically included in the program except beneficiaries with limited benefits.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for

Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-State Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PAHP conducts data accuracy check(s) on specified data elements:
None

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Availability of Dental Providers

Use of Services/Utilization:
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Improvement Projects

Project Requirements:
-Individual PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
None

Non-Clinical Topics:
-Annual Quality Assurance Reviews
-Children preventative measures reports
-Focused Reviews

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

WISCONSIN
Children Come First (CCF)

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

http://dhfs.wisconsin.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency Services, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

WISCONSIN
Children Come First (CCF)

Subpopulations Excluded from Otherwise Included Populations:

- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -Medicare Dual Eligibles

Medicare Dual Eligibles Included:

None

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Community Partnerships
- -Dane County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
- -Mental Health Agency
- -Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee.
- -Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Dane County Human Services Department -- CCF

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. The state reallocates previous funding for institutional placement into community based care. It uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have a special needs to be eligible for enrollment.

QUALITY ACTIVITIES FOR PIHP

WISCONSIN
Children Come First (CCF)

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Collaboration And Teamwork
-Family-Based And Community-Based Service Delivery
-Follow-up after hospitalization for mental illness
-Identification And Process= Service/Care Coordinators

Health Status/Outcomes Quality:
-Cost-Effectiveness Comparison Of This Managed Care Program To Non-Managed Care
-Criminal Offenses And Juvenile Justice Contracts Of Enrollees, Pre-Test And Post-Test

(Case Managers)
-Membership And Process= Child And Family Teams (Plan Of Care Teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process And Content= Plans Of Care
-Process And Content= Service Authorization Plans
-Functional Impairment Of Enrollees, Pre-Test And Post-Test
-Patient satisfaction with care
-Restrictiveness Of Living Arrangements For Enrollees, Pre-Test And Post-Test
-School Attendance And Performance Of Enrollees, Pre-Test And Post-Test

Access/Availability of Care:
-Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

Health Plan Stability/ Financial/Cost of Care:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.
-PIHP/PCP-specific disenrollment rate

Use of Services/Utilization:
-Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

Health Plan/ Provider Characteristics:
-Internal Quality Assurance Review Of Sub-Contracted Providers

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics:
Not Applicable - PIHPs are not required to conduct common project(s)

Clinical Topics:
None

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-MetaStar

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

WISCONSIN

Wraparound Milwaukee

CONTACT INFORMATION

State Medicaid Contact:	Angie Dombrowicki Bureau of Managed Health Care Programs (608) 266-1935
State Website Address:	http://dhfs.wisconsin.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency Services, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

WISCONSIN
Wraparound Milwaukee

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency
-Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Milwaukee County Human Services Department --
Wraparound Milwaukee

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. The state reallocates previous funding for institutional placement into community based care. It uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have a special needs to be eligible for enrollment.

QUALITY ACTIVITIES FOR PIHP

WISCONSIN
Wraparound Milwaukee

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Consumer Self-Report Data:
-Annual family satisfaction survey through Families United Inc. (advocacy agency)
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Collaboration And Teamwork
-Family-Based And Community-Based Service Delivery

Health Status/Outcomes Quality:
-Cost-Effectiveness Comparison Of This Managed Care Program To Non-Managed Care

-Follow-up after hospitalization for mental illness
-Identification And Process= Service/Care Coordinators (Case Managers)
-Membership And Process= Child And Family Teams (Plan Of Care Teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process And Content= Plans Of Care
-Process And Content= Service Authorization Plans
-Criminal Offenses And Juvenile Justice Contracts Of Enrollees, Pre-Test And Post-Test
-Functional Impairment Of Enrollees, Pre-Test And Post-Test
-Patient satisfaction with care
-Restrictiveness Of Living Arrangements For Enrollees, Pre-Test And Post-Test
-School Attendance And Performance Of Enrollees, Pre-Test And Post-Test

Access/Availability of Care:
-Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

Health Plan Stability/ Financial/Cost of Care:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.
-PIHP/PCP-specific disenrollment rate

Use of Services/Utilization:
-Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

Health Plan/ Provider Characteristics:
-Internal Quality Assurance Review Of Sub-Contracted Providers

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics:
Not Applicable - PIHPs are not required to conduct common project(s)

Clinical Topics:
None

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-MetaStar

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

Section:
Concurrent 1915(b)/1915(c) Waiver Programs

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FLORIDA

Florida Comprehensive Adult Day Health Care Program

CONTACT INFORMATION

State Medicaid Contact:

Beth Watson
Agency of Health Care Administration
(850) 922-7353

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 24, 2003

Implementation Date:
April 01, 2004

Waiver Expiration Date:
March 31, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

Adult Day Health Care Facility - Non-risk Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Medical direction, Nutrition, Personal care, Rehabilitation therapy, Skilled Nursing Facility, Social Services, Transportation

Allowable PCPs:
-Adult Day Health Care Center

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Other Insurance

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Recipients less than 75 years of age
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Adult Day Health Care

ADDITIONAL INFORMATION

The Adult Day Health Care facilities are not managed care entities, as defined by the state statutes. They are licensed persuant to Chapter 400 Part 5 of the Florida Statutes.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Beth Watson
Medical Health Care Program Analyst
Agency For Health Care Administration
(850) 922-7353

FLORIDA

Florida Comprehensive Adult Day Health Care Program

State Operating Agency Contact:	Anna Garcia Analyst Department of Elder Affairs (850) 414-2000

PROGRAM DATA

Program Service Area:
County

Initial Waiver Effective Date:
April 01, 2004

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Waiver Expiration Date:
March 31, 2007

Service Delivery

Target Group:
Aged

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

The 1915(b) waiver allows Florida to selectively contract vendors for selected counties to provide the 1915(c) services.

FLORIDA

Florida Medicaid Alzheimers Waiver Program

CONTACT INFORMATION

State Medicaid Contact:	Wendy Smith Florida Agency for Health Care Administration (850) 922-7348
State Website Address:	http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 01, 2004

Implementation Date:
April 01, 2005

Waiver Expiration Date:
February 28, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Community Care for the Elderly Agencies - Fee-for-Service

Service Delivery

Included Services:
Home and Community-Based Waiver Services

Allowable PCPs:
-Home and Community-Based Waiver Providers

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-Persons Under Age 60
-Poverty Level Pregnant Woman

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alzheimer's Waiver Service Provider

ADDITIONAL INFORMATION

The 1915(b) waiver allows for selective contracting and the development of a service provider network to deliver alzheimers disease Medicaid waiver services. There is a monthly capitated case mangement rate paid to the vendors selected through the RFP process. The other waiver services are paid on rates billed to the fiscal agent (ffs).

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

FLORIDA

Florida Medicaid Alzheimers Waiver Program

State Medicaid Agency Contact:

Wendy Smith
Program Administrator
Florida Agency for Health Care Administration
(850) 922-7348

State Operating Agency Contact:

PROGRAM DATA

Program Service Area:
County

Initial Waiver Effective Date:
March 01, 2004

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Waiver Expiration Date:
February 28, 2007

Service Delivery

Target Group:
Aged

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

There is no distinction between the (b) and (c) waivers at the operational level. Target group: Aged refers to beneficiaries over 60 years of age.

MICHIGAN
Specialty Prepaid Inpatient Health Plans

CONTACT INFORMATION

State Medicaid Contact:

Irene Kazieczko
MDCH, Bureau of Community Mental Health Services
(517) 335-0252

State Website Address:

http://www.mdch.michigan.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 26, 1998

Implementation Date:
October 01, 1998

Waiver Expiration Date:
September 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Assertive Community Treatment, Assessments, Assistive Technology *, Behavior Management Review, Child Therapy, Clubhouse, Community Living Supports *, Crisis Interventions, Crisis Residential, Enhanced Pharmacy *, Environmental Modifications *, Extended Observation Beds *, Family Support and Training *, Health Services, Home-based Services, Housing Assistance *, ICF/MR, Inpatient Psychiatric, Intensive Crisis Stabilization, Medication admin/review, MH Therapies, Nursing Facility Monitoring, Occupational, Physical and Speech Therapies, Outpatient Partial Hospitalization, Peer-delivered Support *, Personal care in specialized residential, Prevention-Direct Models *, Respite Care *, Skill-building Assistance *, Substance Abuse, Support and Service Coordination *, Supported Employment *, Targetted Case Management, Transportation, Treatment Planning, Wrap-around for Children and Adolescents *

Allowable PCPs:
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Residing in ICF/MR
-Children Enrolled in Childrens Waiver (Section 1915(c))
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Identified through other health care agencies
-Outreach
-Referred through other health care practitioners/agencies
-Self-referral

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Department of Corrections
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Specialty Employment Agency (Supported Employment)
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bay Arenac CMH
Central Michigan CMH

CEI CMH
Detroit-Wayne CMH

MICHIGAN

Specialty Prepaid Inpatient Health Plans

Genesee County CMH
Kent County CMH
Macomb County CMH
North Country CMH
Oakland County CMH
Saginaw County CMH
Summit Pointe

Kalamazoo County CMH
Lifeways CMH
Muskegon County CMH
Northern Lakes CMH
Pathways CMH
St. Clair County CMH
Washtenaw County CMH

ADDITIONAL INFORMATION

Michigan remains one of the very few, if not the only, state to have incorporated services to persons with Developmental Disabilities into a 1915(b) Freedom of Choice "managed care" waiver. Also, all persons adjudicated Medicaid eligible are deemed enrolled in this Specialty Community Mental Health Services and Supports managed care program. Included services are offered under the authority of 1915(b)(3). Included services with an "asterisk" next to it are state plan services.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:	Irene Kazieczko Director MDCH, Bureau of Community Mental Health Services 517-335-0252
State Operating Agency Contact:	Debra Ziegler HSW Specialist Bureau of Community Health Services Michigan Department of Community Health (517) 373-5322

PROGRAM DATA

Program Service Area:
Statewide

Statutes Waived:
1902(a)(10)(B) Comparability of Services

Initial Waiver Effective Date:
December 12, 2002

Waiver Expiration Date:
December 12, 2010

Service Delivery

Target Group:
Seriously Mentally Ill or Substance Use Disorders
Developmental Disabled

Level of Care:
ICFMR

ADDITIONAL INFORMATION

Under the Michigan Managed Specialty Support and Services Program, PIHPs administer state plan alternatives and 1915(c) waiver services. This managed mental health services program provides support and services to person with serious mental illness, developmental disability and substance use disorders, and children with serious emotional disturbance. Persons served through the 1915(b) waiver use a combination of state plan and 1915 (b)(3) services. Persons enrolled in the C waiver, called the Habilitation Supports Waiver (HSW) use a combination of C waiver services, state plan and 1915 (b)(3) services.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-External Quality Review
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Measures (see below for details)
-PIHP Standards

Use of Collected Data:

-Actuarial analysis
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-MHSIP Consumer Survey

Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of electronic file formats
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PIHP conducts data accuracy check(s) on specified data elements:

None
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Age
-Gender
-Race/Ethnicity
-Social Security

State conducts general data completeness assessments:

Yes

MICHIGAN
Specialty Prepaid Inpatient Health Plans

Performance Measures

Process Quality:
-Follow-up after hospitalization for mental illness

Access/Availability of Care:
-Penetration rates for special populations
-Timelines and screening for inpatient
-Wait time for commencement of service(s)
-Wait time for first appointment with PCP

Health Plan Stability/ Financial/Cost of Care:
None

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percent readmitted to inpatient care within 30 days of discharge
-Rates of rights complaints/1000 served
-Rates of sentinel events/1000 served

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
None

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
-CARF
-COA
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-The Council

EQRO Name:
-Health Service Advisory Group, Phoenix, AZ

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-None

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

CONTACT INFORMATION

State Medicaid Contact:

Christine Bronson
Minnesota Department of Human Services
(651) 431- 2914

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 21, 2005

Implementation Date:
June 01, 2005

Waiver Expiration Date:
July 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Community Based Services, Dental, Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable. Contractors Not Required to Identify PCPs

Enrollment

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Populations Aged 65+
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Reside in Nursing Facility or ICF/MR
-SCHIP Title XXI Children
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
PrimeWest Health System
UCARE
First Plan Blue
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

ADDITIONAL INFORMATION

None

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:	Michelle Long Federal Relations Minnesota Department of Human Services (651)431-2183
State Operating Agency Contact:	Not Applicable

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Initial Waiver Effective Date:
April 01, 2005

Waiver Expiration Date:
June 30, 2008

Service Delivery

Target Group:
Aged

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

1915(c) services must be part of the MCOs provider network.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO Standards
- Monitoring of MCO Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)

Use of Collected Data:
- Beneficiary Plan Selection
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management/care
-Diabetes medication management
-Immunizations for two year olds
-Lead screening rate

Health Status/Outcomes Quality:
-CAHPS

MINNESOTA

Minnesota Senior Care/Minnesota Senior Care Plus

Access/Availability of Care:
-Average distance to PCP

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Use of Services/Utilization:
None

Health Plan/ Provider Characteristics:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:
None

Clinical Topics:
-Adverse Events
-Breast cancer screening (Mammography)
-Cardiovascular Care
-Heart Failure Care
-Leapfrog Reporting
-Pneumonia Care
-Sexually transmitted disease screening
-Treatment of myocardial infraction

Standards/Accreditation

MCO Standards:
-BBA Managed Care Standards
-CMS's PIP Requirements

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Private accreditation organization
-QIO-like entity

Accreditation Required for Participation:
None

EQRO Name:
-MetaStar
-Michigan PRO

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Population Categories Included:
Covers all MCO members

Program Payers:
MCOs

Rewards Model:
Payment incentives/differentials to reward MCOs

MINNESOTA

Minnesota Senior Care/Minnesota Senior Care Plus

Clinical Conditions:
Cardiac Care
Diabetes

Initial Year of Reward:
1999

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

NORTH CAROLINA
Piedmont Cardinal Health Plan (Innovations)

CONTACT INFORMATION

State Medicaid Contact:	Judy Walton Division of Medical Assistance (919) 855-4111
State Website Address:	www.dhhs.state.nc.us/dma

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 06, 2004

Implementation Date:
April 01, 2005

Waiver Expiration Date:
March 31, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Augmentative Communication Services, Care Giver Training, Community Transitions Support, Crisis, Financial Management, Habilitation Services, Home Modifications, Individual Directed Goods and Services, Individual Training Services, Inpatient Mental Health Services, Personal Assistance, Respite, Specialized Consultation Services, Specialized Equipment and Supplies, Supports Brokerage, Vehicle Adaptations

Allowable PCPs:
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

NORTH CAROLINA

Piedmont Cardinal Health Plan (Innovations)

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-Adoption Assistance

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Piedmont Cardinal Health Plan
Piedmont Cardinal Health Plan (Innovations)

ADDITIONAL INFORMATION

None

Concurrent Operating 1915(c) Program

NORTH CAROLINA
Piedmont Cardinal Health Plan (Innovations)

CONTACT INFORMATION

State Medicaid Agency Contact:	Judy Walton Program Administrator Division of Medical Assistance 919-855-4100
State Operating Agency Contact:	Not Applicable

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(10)(C)(i)(III) Income and Resource Rules
1902(a)(1) Statewideness

Initial Waiver Effective Date:
April 01, 2005

Waiver Expiration Date:
March 31, 2008

Service Delivery

Target Group:
Disabled
Aged and Disabled
Mentally Retarded
Developmental Disabled
Mentally Retarded and Developmentally Disabled
Seriously Mentally Ill or Substance Use Disorders

Level of Care:
Hospital
ICFMR

ADDITIONAL INFORMATION

The Piedmont Cardinal Health Plan (PCHP), which is a 1915(b) waiver, and the Innovations waiver operate concurrently and are restriced to a five-county area of North Carolina. The PCHP waiver enables the State to mandate beneficiaries into a single Prepaid Inpatient Health Plan (PIHP). The PIHP is the states mental regional health, developmental disabilities, and substance abuse (MH/DD/SA) authority that serves the five county area covered by the waivers. Thus, Innovations home and community based services are administered by the MD/DD/SA authority in a capitated, managed care environment along with Medicaid State Plan mental health and substance service.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Network Data
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

-Provider Data

Consumer Self-Report Data:
-Plan developed and state approved consumer survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
-Ambulatory follow up within 7 days after discharge from mental health facility
-Ambulatory follow up within 7 days after discharge from substance abuse facility
-Follow-up after hospitalization for mental illness
-Number of Consumers moved from institutional care to community care
-Readmission rates for mental health
-Readmission rates for substance abuse

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Call Abandonment
-Call Answer Timeliness
-Initiation and Engagement of Alcohol and other drug dependence treatment
-Out of Network Services
-Service Availability/Accessibility
-Timeliness of initial service delivery

Use of Services/Utilization:
-Chemical dependency services utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-MH Utilization percentage of members receiving inpatient, day/night, ambulatory and other support services
-Percentage of members receiving inpatient, day/night, ambulatory and support services for chemical dependency
-Utilization management of the provision of high use services

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Network Capacity

Beneficiary Characteristics:
-Diversity of Medicaid Membership

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Impact of multisystemic therapy on residential placements
-Impact of the provision of intensive in-home services on residential placements
-Reduce the number of state hospitalizations

Non-Clinical Topics:
-Adherence to reporting requirements
-Complaints processing
-provider reimbursement timelines

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-Michigan Peer Review Organization (MPRO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

TEXAS
STAR+PLUS

CONTACT INFORMATION

State Medicaid Contact:

Pam Coleman
Health and Human Services Commission
(512) 491-1302

State Website Address:

http://www.hhsc.state.tx.us/starplus/starplus.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
TAA/Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 30, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
June 30, 2008

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Internists
-Physician Assistants
-Nurse Practitioners
-Nurse Midwives
-Rural Health Clinics (RHCs)
-Federally Qualified Health Centers (FQHCs)

TEXAS
STAR+PLUS

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in a Nursing Facility or ISF/MR, Reside in a state school or other 24 hour facility, Participating in a HCBS waiver other than the 1915 (c) Nursing Facility Waiver
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Physician, X-Ray

Allowable PCPs:
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Participating in a HCBS waiver other than the 1915 (c) Nursing Facility Waiver
-Medicare Dual Eligibles
-SSI Adults
-Reside in a Nursing Facility or ISF/MR,
-Reside in a state school or other 24 hour facility

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

TEXAS
STAR+PLUS

Strategies Used to Identify Persons with Complex (Special) Needs:	**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Uses eligibility data to identify members of these groups	-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup- STAR+PLUS
Evercare (Medicare)
Evercare
Texas Health Network

ADDITIONAL INFORMATION

Blind/disabled/aged adults who are SSI or deemed SSI by CMS are mandatory to participate in the MCO model. Blind/disabled children who are SSI or deemed SSI by CMS have the choice of participating in the MCO model or the PCCM model.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Bill Fransworth
Policy & Information Specialist
Health & Human Services Commission
(512)491-1301

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
County

Initial Waiver Effective Date:
February 01, 1998

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Waiver Expiration Date:
January 31, 2008

Service Delivery

Target Group:
Aged and Disabled

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

Both b&c waivers are operating through the STAR+PLUS program which integrates acute and long term care services for SSI enrollees in Harris County.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
-State-developed Survey

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

State conducts general data completeness assessments:

Yes

-Gender-appropriate diagnosis/procedure
-Medicaid Eligibility
-Plan Enrollment
-Preparing HEDIS and risk adjustment software

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in adolescents

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to LTSS providers
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-None

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:
-Diabetes care and management
-Influenza Immunizations

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Institute for Child Health Policy, University of Florida

Accreditation Required for Participation:
None

EQRO Name:
-Institute for Child Health Policy

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data
-Validation of performance improvement projects

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Does not perform any of the Quality Activities for the PCCM Program

Consumer Self-Report Data:
None

Use of Collected Data:
None

WISCONSIN

Family Care

CONTACT INFORMATION

State Medicaid Contact:

Charles Jones
Wisconsin Department of Health and Family Services
(608) 266-0991

State Website Address:

http://dhfs.wisconsin.gov/LTCare/INDEX.HTM

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Southeastern Wisconsin Area Agency on Aging

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 2004

Implementation Date:
January 01, 2004

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) Choice of PIHP

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

LTC PIHP - Risk-based Capitation

Service Delivery

Included Services:
1915(c) Waiver Services, Case Management, Disposable Medical Supplies, Durable Medical Equipment, Duty Nursing, Home Health, ICF-MR, In-home Psychotherapy, Language Pathology, Mental Health Comminity Support Program, Occupational Therapy, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Physical Therapy, Respiratory Therapy, Skilled Nursing, Skilled Nursing Facility, Speech Therapy, Transportation

Allowable PCPs:
-Not applicable, primary care is carved out

Enrollment

WISCONSIN

Family Care

Populations Voluntarily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Under Age 60 in Milwaukee County
-Enrolled in Another Managed Care Program
-Have an Eligibility Period that Is Only Retroactive

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Populations Mandatorily Enrolled:

None

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

Yes

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

No

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All Target Groups Are Persons with Special Needs

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Protective Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Care

ADDITIONAL INFORMATION

Milwaukee County Department of Aging serves only persons age 60 and over.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

WISCONSIN
Family Care

State Medicaid Agency Contact:

Charles Jones
Lead Waiver/Policy Analyst
WI Department of Health & Social Services
(608) 266-0991

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Initial Waiver Effective Date:
January 01, 2004

Waiver Expiration Date:
December 31, 2007

Service Delivery

Target Group:
Aged and Disabled
Mentally Retarded
Developmental Disabled

Level of Care:
Nursing Home
ICFMR

ADDITIONAL INFORMATION

Family care is capitated, full risk managed care program for the delivery of long-term care services. Family care 1915(b) Long Term Care PIHP includes 1915(c) waiver services and Medicaid State Plan Long Term Care Services. Primary and acute health care are carved out, but remain available to enrollees through the Medicaid State Plan. Every enrollee participates with an interdisciplinary care management team that, at minimum includes a nurse and a social worker, in a member-centered planning process to design an individualized service plan (ISP). The ISP is designed to identify the members long-term care needs and authorize services to achieve identified incomes. The assessment mythology uses: 1) a structured validated member interview tool to evaluate member perception of performance; 2) a structured review of a sample of ISPs by the State External Quality Review Organization; 3) annual State evaluation and certification of the PIHP network of providers to ensure adequate access and capacity; and 4) ongoing utilization review and focus studies to identify areas of performance improvement projects and other quality improvement strategies. Aging and Disability Resource Centers are established in each county where Family Care is available to act as a single entry point for information and access to services for persons in need of long-term care. Aged and Related populations and Blind/Disabled Adults and Related populations are voluntary.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Individualized Service Plan Reviews
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

-Structured Member Outcome Interviews

Consumer Self-Report Data:
-Structured Member Outcome Interviews

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Member LTC outcomes present
-Support for member LTC outcomes provided

Health Status/Outcomes Quality:
-Member health and safety outcomes present
-Support for member health and safety outcomes provided

Access/Availability of Care:
-State assessment of adequate network capacity

Use of Services/Utilization:
-NF and ICF-MR utilization

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification
-State review for cultural competency

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-PIHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics:

Not Applicable - PIHPs are not required to conduct common project(s)

Clinical Topics:

-Substance Use Disorders treatment after detoxification service

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

Accreditation Required for Participation:
None

EQRO Name:
-MetaStar, Inc.

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

Section:
1905(t) Waiver Programs

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COLORADO
Primary Care Physician Program

CONTACT INFORMATION

State Medicaid Contact:

Jerry Smallwood
Dept. of Health Care Policy and Financing
303-866-5947

State Website Address:

http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1905(t)

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus, INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 30, 2003

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Hearing, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Pharmacy, Physician, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

No

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Physician Program

ADDITIONAL INFORMATION

This program provides beneficiaries the option of a fee-for-service physician who acts as a gatekeeper and refers for specialty care.

QUALITY ACTIVITIES FOR PCCM

COLORADO
Primary Care Physician Program

Quality Oversight Activities:
-Consumer Self-Report Data
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Program Evaluation
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes management/care
-Initiation of prenatal care - timeliness of

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

Provider Characteristics:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Use of Services/Utilization:
-Percentage of beneficiaries with at least one dental visit

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

Clinical Topics:
None

Non-Clinical Topics:
None

SOUTH CAROLINA
Medical Homes Network

CONTACT INFORMATION

State Medicaid Contact:

Beverly Hamilton
Division of Care Management
(803)898-4502

State Website Address:

www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1905(t)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2004

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
None

- -Aged and Related Populations
- -Foster Care Children
- -TITLE XXI SCHIP
- -Special Needs Children (State defined)
- -Special Needs Children (BBA defined)
- -Poverty-Level Pregnant Women
- -Medicare Dual Eligibles
- -American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:

- -Enrolled in Another Managed Care Program
- -Reside in Nursing Facility or ICF/MR
- -Participate in HCBS Waiver

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Uses eligibility data to identify members of these groups
- -Uses enrollment forms to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Developmental Disabilities Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency
- -Social Services Agencies
- -Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Homes Network

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
- -Focused Studies
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

Consumer Self-Report Data:
None

Use of Collected Data:
- -Beneficiary Provider Selection
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Provider Profiling

Performance Measures

Process Quality:
None

Access/Availability of Care:
None

Provider Characteristics:
None

Health Status/Outcomes Quality:
- -Patient satisfaction with care
- -Percentage of low birth weight infants

Use of Services/Utilization:
- -Drug Utilization
- -Emergency room visits/1,000 beneficiaries
- -Inpatient admissions/1,000 beneficiaries
- -Number of primary care case manager visits per beneficiary
- -Number of specialist visits per beneficiary
- -Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

Beneficiary Characteristics:
None

Performance Improvement Projects

Clinical Topics:
- -Asthma management
- -Childhood Immunization
- -Diabetes management
- -Emergency Room service utilization
- -Low birth-weight baby
- -Pharmacy management
- -Pre-natal care

Non-Clinical Topics:
None

Section:
PACE Programs

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CALIFORNIA

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Delmira Rosas - Pettit Contract Manager Office of Long Term Care (916) 440-7543
State Website Address:	http://www.dhs.ca.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for anorexia, weight loss, weight gain, Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Agents when used to promote fertility, Benzodiazepines, Drugs used to promote fertility, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)

PACE Organization

Approved PACE Organization Name:	Center for Elders Independence
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Peter Szutu 510 17th Street, Suite 400 Oakland, CA 94612 (510) 433-1160

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a risk-adjusted payment rate and a prospective monthly payment for each Medicaid participant that is developed in accordance with a fee-for-service equivalent (FFSE) methodology, also referred to as the Upper Payment Limit. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. A PACE organization may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

CALIFORNIA

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Delmira Rosas - Pettit Contract Manager Office of Long Term Care (916) 440-7543
State Website Address:	http://www.dhs.ca.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for anorexia, weight loss, weight gain, Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Agents when used to promote fertility, Benzodiazepines, Drugs used to promote fertility, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)

PACE Organization

Approved PACE Organization Name:	Sutter Senior Care
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Dianna Steward 1234 U Street Sacramento, CA 95818 (916) 446-3100

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Della Cabrera Contract Manager Office of Long Term Care (916) 440-7532
State Website Address:	http://www.dhs.ca.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for anorexia, weight loss, weight gain, Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Agents when used to promote fertility, Benzodiazepines, Drugs used to promote fertility, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)

PACE Organization

Approved PACE Organization Name:	On Lok Senior Health Services
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Robert Edmondson 1333 Bush Street San Francisco, CA 94109 (415) 292-8888

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Della Cabrera Contract Manager Office of Long Term Care (916) 440-7532
State Website Address:	http://www.dhs.ca.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for anorexia, weight loss, weight gain, Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Agents when used to promote fertility, Benzodiazepines, Drugs used to promote fertility, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)

PACE Organization

Approved PACE Organization Name:	AltaMed Health Services Corporation
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Sophia Guel-Valenzuela 5425 East Pomona Blvd Los Angeles, CA 90022 (323) 728-0411

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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COLORADO

Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Beverley Dahan Contract Manager Department of Health Care Policy and Financing 303-866-2148
State Website Address:	http://www.CHCPF.state.co.us

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for anorexia, weight loss, weight gain, Agents when used for symptomatic relief of cough and colds, Barbituates, Benzodiazepines, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)

PACE Organization

Approved PACE Organization Name:	Total Long Term Care
Program Agreement Effective Date:	April 01, 2003
PACE Contact:	Beverley Dahan 1570 Grant Denver, CO 80203 (303) 869-2148

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

FLORIDA
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Beth Watson Program Administrator Agency for Health Care Administration (850) 922-7353
State Website Address:	http://www.fdhc.state.fl.us

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Nonprescription drugs

PACE Organization

Approved PACE Organization Name:	Florida PACE Centers, Inc.
Program Agreement Effective Date:	January 01, 2003
PACE Contact:	Daniel Brady 5200 NE 2nd Avenue Miami, FL 33137 (305) 531-5341

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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KANSAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Debra Bachmann Manager, PACE Program Kansas Health Policy Authority (785) 291-3438
State Website Address:	http://www.khpa.ks.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Nonprescription drugs

PACE Organization

Approved PACE Organization Name:	Via Christi Healthcare Outreach Program for the Elders
Program Agreement Effective Date:	September 01, 2002
PACE Contact:	Mark Bailey 935 S. Glendale Wichita, KS 67208 (316) 858-1111

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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MARYLAND
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Karen Armacost Administrator Department of Health and Mental Hygiene (410) 540-7044
State Website Address:	http://www.dhmh.state.md.us

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name:	Hopkins Elder Plus
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Karen Armacost 4940 Eastern Ave. Baltimore, MD 21224 410-550-7044

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Diane Flanders
Director, Coordinated Care Systems
Division of Medical
Assistance
(617) 222-7409

State Website Address:

http://www.mass.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:

Agents when used for anorexia, weight loss, weight gain, Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Agents when used to promote fertility, Barbituates, Benzodiazepines, Drugs used to promote fertility, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations), Smoking Cessation (except dual eligibles as Part D will cover)

PACE Organization

Approved PACE Organization Name:

Elder Service Plan of Cambridge Health Alliance

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Carol Murphy
270 Green Street
Cambridge, MA 02139
(617) 499-8366

Approved PACE Organization Name:

Elder Service Plan of Harbor Health Services Inc

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Carol Crawford
2216 Dorchester Avenue
Dorchester, MA 02124
(617) 296-5100

MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Uphams Elder Service Plan

Program Agreement Effective Date: November 01, 2002

PACE Contact:
Jay Trivedi
1140 Dorchester Avenue
Dorchester, MA 02125
(617) 288-0970

Approved PACE Organization Name: Elder Service Plan of East Boston

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Laura Wagner
10 Gove Street
East Boston, MA 02128
(617) 568-6413

Approved PACE Organization Name: Elder Service Plan at Fallon Community Health Plan

Program Agreement Effective Date: November 01, 2002

PACE Contact:
Karen Longo
277 East Mountain Street
Worcester, MA 01605
(508) 852-2026

Approved PACE Organization Name: Elder Service Plan of the North Shore, Inc.

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Carol Suleski
20 School Street
Lynn, MA 01901
781-581-7565

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

MICHIGAN

Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Debbie Katcher Long Term Care Specialist Department of Community Health (517) 373-7335
State Website Address:	http://www.michigan.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name:	Henry Ford Health System Center for Senior Independence
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Michael Simowski 3800 W. Outer Drive, Suite 240 Detroit, MI 48255 (313) 653-2222

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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MISSOURI

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Shelley Farris MC+ Operations Manager Department of Social Services, Division of Medical Services (573) 751-5178
State Website Address:	www.missouri.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name:	Alexian Brothers Community Services
Program Agreement Effective Date:	November 01, 2001
PACE Contact:	Deno Fabbre 3900 South Grand St. Louis, MO 63118 314-771-5800

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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NEW MEXICO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Consuelo Trujillo Planning and Operation Bureau Chief NM HSD/Medical Assistance Division (505) 827-3164
State Website Address:	http://www.state.nm.us/hsd/mad/Index.html

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name:	Total Community Care
Program Agreement Effective Date:	July 01, 2004
PACE Contact:	Gina DeBlassie 904 A Los Lomas NE Albuquerque, NM 87102 505-924-2606

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Linda Gowdy
Director, Bureau of Continuing Care Initiatives
Office of Managed Care, NYS Dept of Health
(518) 474-6965

State Website Address: www.health.state.ny.us

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts: Nonprescription drugs

PACE Organization

Approved PACE Organization Name: Independent Living for Seniors, Inc.

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Joanne Tallinger
2066 Hudson Ave.
Rochester, NY 14617
(585) 922-2800

Approved PACE Organization Name: PACE CNY

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Penny Abulencia
100 Malta Lane
North Syracuse, NY 13212
(315) 452-5800

Approved PACE Organization Name: Eddy Senior Care

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Bernadette Hallam
504 State Street
Schenectady, NY 12305
(518) 382-3290

NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name:	Comprehensive Care Management Corporation
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Susan Aldrich 612 Allerton Avenue Bronx, NY 10457 (718) 515-8600

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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OHIO
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Lisa Walsh
Aging Policy, Bureau of Community Access
Ohio Department of Job and Family Services
(614) 387-7944

State Website Address:

http://www.state.oh.us/odjfs/index.stm

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:

Agents when used for anorexia, weight loss, weight gain, Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Barbituates, Benzodiazepines, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations), Smoking Cessation (except dual eligibles as Part D will cover)

PACE Organization

Approved PACE Organization Name: Concordia Care

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Janis Faenhrich, CEO
2373 Euclid Heights Blvd.
Cleveland Heights, OH 44106
(216) 791-3580

Approved PACE Organization Name: TriHealth Senior Link

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Steve Mombach, Director
619 Oak St.
Cincinnati, OH 45206
(513) 531-5110

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a risk-adjusted payment rate and a prospective monthly payment for each Medicaid participant that is developed in accordance with a fee-for-service equivalent (FFSE) methodology, also referred to as the Upper Payment Limit. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. A PACE organization may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

OREGON

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	David Allm PACE Coordinator Oregon Dept. of Human Services (503) 945-6407
State Website Address:	http://www.dhs.state.or.us

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name:	Providence Elder Place
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Don Keister 13007 NE Gleason Portland, OR 97230 (503) 215-3612

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	James Pezzuti Director, Division of Long Term Care Client Servic PA Department of Public Welfare (717) 772-2525
State Website Address:	www.state.pa.us

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name:	LIFE - University of Pennsylvania
Program Agreement Effective Date:	January 01, 2002
PACE Contact:	Wayne Pendleton 4101 Woodland Avenue Philadelphia, PA 19104 (215) 573-7200
Approved PACE Organization Name:	Community - LIFE
Program Agreement Effective Date:	March 01, 2004
PACE Contact:	Richard DiTommaso 2400 Ardmore Boulevard, Suite 700 Pittsburgh, PA 15221 (412) 664-1448
Approved PACE Organization Name:	LIFE - Pittsburgh
Program Agreement Effective Date:	May 01, 2005
PACE Contact:	Joann Gago 875 Greentree Road, Suite 200, One Parkway Center Pittsburgh, PA 15220 (412) 388-8042

PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: LIFE - St. Agnes

Program Agreement Effective Date: October 01, 2005

PACE Contact:

Emily Amerman
1900 South Broad Street
Philadelphia, PA 19145
(215) 339-4528

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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RHODE ISLAND
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Frank Spinelli Administrator, Center for Adult Health RI Department of Human Services (401) 462-1892
State Website Address:	www.dhs.state.ri.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for anorexia, weight loss, weight gain, Agents when used for symptomatic relief of cough and colds, Barbituates, Benzodiazepines, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)

PACE Organization

Approved PACE Organization Name:	PACE Organization of Rhode Island
Program Agreement Effective Date:	November 01, 2005
PACE Contact:	Jen Jaswell 225 Chapman Street Providence, RI 02905 (401) 490-6566

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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SOUTH CAROLINA

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	George Maky Department Head, Division of CLTC-Waiver Mgt. South Carolina Dept of Health and Human Services (803) 898-2711
State Website Address:	www.dhhs.state.sc.us

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Nonprescription drugs

PACE Organization

Approved PACE Organization Name:	Palmetto SeniorCare
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Judy Baskins Palmetto SeniorCare, 5 Richland Medical Park Columbia, SC 29203 (803) 434-3770

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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TENNESSEE

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	J D Hickey Deputy Commissioner TennCare (615) 507-6444
State Website Address:	http://www.state.tn.us/tenncare

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for anorexia, weight loss, weight gain, Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Agents when used to promote fertility, Barbituates, Benzodiazepines, Drugs used to promote fertility, Nonprescription drugs, Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)

PACE Organization

Approved PACE Organization Name:	Alexian Brothers Community Services
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Viston Taylor 425 Cumberland Street Suite 110 Chattanooga, TN 37404 (423) 698-0802

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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TEXAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Daneen Machicek
Program Manager
Department of Aging and Disability Services
(512) 438-2756

State Website Address:

www.dads.state.tx.us/business/pace/index.ht

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts: None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name: Bienvivir Senior Health Services

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Rosemary Castillo
2300 Mckinley Ave.
El Paso, TX 78751
(512) 438-4882

Approved PACE Organization Name: Jan Werner Adult Day Care Center

Program Agreement Effective Date: March 01, 2005

PACE Contact:

Alana Chilcote
3108 South Fillmore
Amarillo, TX 79110
(512) 438-4882

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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WASHINGTON

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Karen Fitzharris Program Manager ADSA (360) 725-2446
State Website Address:	www.dshs.wa.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	Agents when used for cosmetic purposes or hair growth, Agents when used for symptomatic relief of cough and colds, Nonprescription drugs

PACE Organization

Approved PACE Organization Name:	Providence Elderplace - Seattle
Program Agreement Effective Date:	July 27, 2000
PACE Contact:	Ellen Garcia 4515 Martin Luther King Jr. Way So., Suite 100 Seattle, WA 98108 (206) 320-5325

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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WISCONSIN

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Cecilia Chathas Project Manager Wisconsin Department of Health and Family Services (608) 267-2923
State Website Address:	http://dhfs.wisconsin.gov

Part D Benefit

Coverage of Part D Excluded Drugs in PACE Contracts:	None - managed care entity provides standard prescription drug coverage

PACE Organization

Approved PACE Organization Name:	Community Care Organization
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Paul F. Soczynski 1555 South Layton Boulevard Milwaukee, WI 53215 (414) 385-6600

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, a PACE organization coordinates and provides comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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National Summary Tables

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Operating Authorities by State as of June 30, 2006							
State	1915(b)	1115(a)	1932(a)	1915(a), voluntary	Concurrent 1915(b)/(c)	PACE	1905(t)
Alabama	x			x			
*Alaska	x						
Arizona		x					
Arkansas	x						
California	x	x	x	x		x	
Colorado	x			x		x	x
Connecticut	x						
Delaware		x					
District of Columbia			x	x			
Florida	x				x	x	
Georgia	x		x				
Hawaii		x					
Idaho	x						
Illinois				x			
Indiana	x						
Iowa	x		x				
Kansas			x			x	
Kentucky	x	x	x				
Louisiana			x				
Maine			x				
Maryland		x				x	
Massachusetts		x				x	
Michigan	x				x	x	
Minnesota	x	x	x	x	x		
Mississippi	x			x			
Missouri	x	x				x	
Montana	x						
Nebraska	x		x				
Nevada			x				
New Hampshire	x						
New Jersey	x		x				
New Mexico	x					x	
New York	x	x		x		x	
North Carolina			x		x		
North Dakota			x				
Ohio			x			x	
Oklahoma		x	x				
Oregon	x	x				x	
Pennsylvania	x			x		x	
Puerto Rico				x			
Rhode Island		x				x	
South Carolina				x		x	x
South Dakota			x	x			
Tennessee		x				x	
Texas	x				x	x	
Utah	x	x					
Vermont		x					
*Virgin Islands							
Virginia	x						
Washington	x		x			x	
West Virginia	x						
Wisconsin		x	x	x	x	x	
*Wyoming							

*These States do not have managed care.

Medicaid Programs that Include Dental Services as of June 30, 2006

State	Program Name	Managed Care Entity	Operating Authority
ALABAMA	Patient 1st	PCCM Provider	1915(b)
ARIZONA	Arizona Health Care Cost Containment System (AHCCCS)	MCO (Comprehensive Benefits)	1115(a)
CALIFORNIA	Prepaid Health Plan Program	Dental PAHP	1915(a), voluntary
CALIFORNIA	Sacramento Geographic Managed Care (CCS/Dental)	Dental PAHP	1932(a), 1915(b)
CALIFORNIA	Senior Care Action Network	*Social HMO	1115(a)
CONNECTICUT	HUSKY A	MCO (Comprehensive Benefits)	1915(b)
DELAWARE	Diamond State Partners	*Enhanced Fee for Service Model	1115(a)
DISTRICT OF COLUMBIA	District of Columbia Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1932(a)
DISTRICT OF COLUMBIA	Health Services for Children with Special Needs	Medical-only PIHP	1915(a), voluntary
FLORIDA	Managed Health Care	Dental PAHP	1915(b)
FLORIDA	Managed Health Care	MCO (Comprehensive Benefits)	1915(b)
FLORIDA	Managed Health Care	PCCM Provider	1915(b)
GEORGIA	Georgia Healthy Families	MCO (Comprehensive Benefits)	1932(a)
HAWAII	Hawaii QUEST	MCO (Comprehensive Benefits)	1115(a)
IDAHO	Healthy Connections	PCCM Provider	1915(b)
INDIANA	Hoosier Healthwise	MCO (Comprehensive Benefits)	1915(b)
KENTUCKY	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	1115(a)
KENTUCKY	Kentucky Patient Access and Care (KENPAC) Program	PCCM Provider	1932(a)
MARYLAND	HealthChoice	MCO (Comprehensive Benefits)	1115(a)
MASSACHUSETTS	Mass Health	PCCM Provider	1115(a)
MINNESOTA	Minnesota Disability Health Options (MnDHO)	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	Minnesota Prepaid Medical Assistance Program-1115(a)	MCO (Comprehensive Benefits)	1115(a)
MINNESOTA	Minnesota Prepaid Medical Assistance Program-1932(a)	MCO (Comprehensive Benefits)	1932(a)
MINNESOTA	Minnesota Senior Health Options Program (MSHO)	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	MinnesotaCare Program For Families And Children	MCO (Comprehensive Benefits)	1115(a)
MINNESOTA	Minnesota Senior Care/Minnesota Senior Care Plus	MCO (Comprehensive Benefits)	1915(b)/(c)
MISSOURI	MC+ Managed Care/1115	MCO (Comprehensive Benefits)	1115(a)
MISSOURI	MC+ Managed Care/1915b	MCO (Comprehensive Benefits)	1915(b)
MONTANA	Montana Passport to Health	PCCM Provider	1915(b)
MONTANA	Passport To Health	PCCM Provider	1915(b)
NEVADA	Mandatory Health Maintenance Program	MCO (Comprehensive Benefits)	1932(a)
NEW JERSEY	NJ FamilyCare - 1915(b)	MCO (Comprehensive Benefits)	1915(b)
NEW JERSEY	NJ FamilyCare - 1932 (a)	MCO (Comprehensive Benefits)	1932(a)
NEW MEXICO	NEW MEXICO SALUD!	MCO (Comprehensive Benefits)	1915(b)/(c)
NEW YORK	Managed Long Term Care Program	Long Term Care PIHP	1915(a), voluntary

*Managed Care Entity Type is considered "Other".

Medicaid Programs that Include Dental Services as of June 30, 2006

State	Program Name	Managed Care Entity	Operating Authority
NEW YORK	Partnership Plan - Family Health Plus	MCO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan - Family Health Plus	PPO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan - Medicaid Advantage	MCO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan Medicaid Managed Care Program	PCCM Provider	1115(a)
NORTH DAKOTA	North Dakota Medicaid Managed Care Program	PCCM Provider	1932(a)
OHIO	State Plan Amendment for Ohio's Full-Risk Managed Care Program	MCO (Comprehensive Benefits)	1932(a)
OREGON	Oregon Health Plan	Dental PAHP	1115(a)
PENNSYLVANIA	Access Plus Program	PCCM Provider	1915(b)
PENNSYLVANIA	HealthChoices	MCO (Comprehensive Benefits)	1915(b)
PENNSYLVANIA	Long Term Care Capitated Assistance Program (PIHP)	Medical-only PIHP	1915(a), voluntary
PENNSYLVANIA	Voluntary HMO Contracts	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Medicare Platino	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	1915(a), voluntary
SOUTH DAKOTA	Dental Program	Dental PAHP	1915(a), voluntary
TENNESSEE	TennCare	*Dental Benefit Manager	1115(a)
TEXAS	STAR	MCO (Comprehensive Benefits)	1915(b)
TEXAS	STAR	PCCM Provider	1915(b)
UTAH	Primary Care Network (PCN)	PCCM Provider	1115(a)
VIRGINIA	MEDALLION/Medallion II	PCCM Provider	1915(b)
WEST VIRGINIA	Mountain Health Trust	MCO (Comprehensive Benefits)	1915(b)
WISCONSIN	BadgerCare [SCHIP]	MCO (Comprehensive Benefits)	1115(a)
WISCONSIN	Medicaid HMO Program	MCO (Comprehensive Benefits)	1932(a)
WISCONSIN	Medicaid SSI Managed Care Program	MCO (Comprehensive Benefits)	1932(a)
WISCONSIN	Wisconsin Partnership Program	MCO (Comprehensive Benefits)	1115(a)

*Managed Care Entity Type is considered "Other".

Medicaid Program that include Pharmacy services as of June 30, 2006

State	Program Name	Managed Care Entity Type	Operating Authority
ALABAMA	Patient 1st	PCCM Provider	1915(b)
ARIZONA	Arizona Health Care Cost Containment System (AHCCCS)	MCO (Comprehensive Benefits)	1115(a)
ARIZONA	Arizona Health Care Cost Containment System (AHCCCS)	MH/SUD PIHP	1115(a)
CALIFORNIA	AIDS Healthcare Foundation	MCO (Comprehensive Benefits)	1915(a), voluntary
CALIFORNIA	Caloptima	HIO	1915(b)
CALIFORNIA	Central Coast Alliance for Health	HIO	1915(b)
CALIFORNIA	Health Plan of San Mateo	*MCO/COHS	1915(b)
CALIFORNIA	Partnership Health Plan of California	HIO	1915(b)
CALIFORNIA	Prepaid Health Plan Program	MCO (Comprehensive Benefits)	1915(a), voluntary
CALIFORNIA	Sacramento Geographic Managed Care (CCS/Dental)	MCO (Comprehensive Benefits)	1932(a)/1915(b)
CALIFORNIA	San Diego Geographic Managed Care	MCO (Comprehensive Benefits)	1932(a)
CALIFORNIA	Santa Barbara Health Initiative	HIO	1915(b)
CALIFORNIA	Senior Care Action Network	*Social HMO	1115(a)
CALIFORNIA	Two-Plan Model Program	MCO (Comprehensive Benefits)	1932(a)
COLORADO	Managed Care Program	MCO (Comprehensive Benefits)	1915(a), voluntary
COLORADO	Managed Care Program	Medical-only PIHP	1915(a), voluntary
COLORADO	Primary Care Physician Program	PCCM Provider	1905(t)
CONNECTICUT	HUSKY A	MCO (Comprehensive Benefits)	1915(b)
DELAWARE	Diamond State Partners	*Fee for Service Model	1115(a)
DISTRICT OF COLUMBIA	District of Columbia Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1932(a)
DISTRICT OF COLUMBIA	Health Services for Children with Special Needs	Medical-only PIHP	1915(a), voluntary
GEORGIA	Georgia Healthy Families	MCO (Comprehensive Benefits)	1932(a)
HAWAII	Hawaii QUEST	MCO (Comprehensive Benefits)	1115(a)
HAWAII	Hawaii QUEST	MH/SUD PIHP	1115(a)
IDAHO	Healthy Connections	PCCM Provider	1915(b)
INDIANA	Hoosier Healthwise	MCO (Comprehensive Benefits)	1915(b)
INDIANA	Medicaid Select	PCCM Provider	1915(b)
KANSAS	HealthConnect Kansas	PCCM Provider	1932(a)
KANSAS	HealthWave 19	MCO (Comprehensive Benefits)	1932(a)
KENTUCKY	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	1115(a)
KENTUCKY	Kentucky Patient Access and Care (KENPAC) Program	PCCM Provider	1932(a)
MARYLAND	HealthChoice	MCO (Comprehensive Benefits)	1115(a)
MASSACHUSETTS	Mass Health	MCO (Comprehensive Benefits)	1115(a)
MASSACHUSETTS	Mass Health	PCCM Provider	1115(a)
MICHIGAN	Comprehensive Health Plan	MCO (Comprehensive Benefits)	1915(b)

*Managed Care Entity Type is "Other".

Medicaid Program that include Pharmacy services as of June 30, 2006

State	Program Name	Managed Care Entity Type	Operating Authority
MICHIGAN	Specialty Prepaid Inpatient Health Plans	MH/SUD PIHP	1915(b)/(c)
MINNESOTA	Minnesota Disability Health Options (MnDHO)	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	Minnesota Prepaid Medical Assistance Program-1115(a)	MCO (Comprehensive Benefits)	1115(a)
MINNESOTA	Minnesota Prepaid Medical Assistance Program-1932(a)	MCO (Comprehensive Benefits)	1932(a)
MINNESOTA	Minnesota Senior Care/Minnesota Senior Care Plus	MCO (Comprehensive Benefits)	1915(b)/(c)
MINNESOTA	Minnesota Senior Health Options Program (MSHO)	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	MinnesotaCare Program For Families And Children	MCO (Comprehensive Benefits)	1115(a)
MISSOURI	MC+ Managed Care/1115	MCO (Comprehensive Benefits)	1115(a)
MISSOURI	MC+ Managed Care/1915b	MCO (Comprehensive Benefits)	1915(b)
MONTANA	Montana Passport to Health	PCCM Provider	1915(b)
NEVADA	Mandatory Health Maintenance Program	MCO (Comprehensive Benefits)	1932(a)
NEW JERSEY	NJ FamilyCare - 1915(b)	MCO (Comprehensive Benefits)	1915(b)
NEW JERSEY	NJ FamilyCare - 1932(a)	MCO (Comprehensive Benefits)	1932(a)
NEW MEXICO	NEW MEXICO SALUD!	MCO (Comprehensive Benefits)	1915(b)/(c)
NEW MEXICO	NEW MEXICO SALUD!	Mental Health (MH) PIHP	1915(b)/(c)
NEW YORK	Partnership Plan - Family Health Plus	*PPO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan - Family Health Plus	MCO (Comprehensive Benefits)	1115(a)
NORTH DAKOTA	North Dakota Medicaid Managed Care Program	PCCM Provider	1932(a)
OHIO	State Plan Amendment for Ohio's Full-Risk Managed Care Program	MCO (Comprehensive Benefits)	1932(a)
OREGON	Oregon Health Plan	MCO (Comprehensive Benefits)	1115(a)
PENNSYLVANIA	Access Plus Program	PCCM Provider	1915(b)
PENNSYLVANIA	HealthChoices	MCO (Comprehensive Benefits)	1915(b)
PENNSYLVANIA	Long Term Care Capitated Assistance Program (PIHP)	Medical-only PIHP	1915(a), voluntary
PENNSYLVANIA	Voluntary HMO Contracts	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Medicare Platino	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Puerto Rico Health Care Plan	MH/SUD PIHP	1915(a), voluntary
RHODE ISLAND	Rite Care	MCO (Comprehensive Benefits)	1115(a)
SOUTH CAROLINA	Health Maintenance Organization (HMO)	MCO (Comprehensive Benefits)	1915(a), voluntary
SOUTH CAROLINA	Medically Fragile Children Program (MFCP)	Medical-only PAHP	1915(a), voluntary
TENNESSEE	TennCare	*Pharmacy Benefit Manager	1115(a)
TENNESSEE	TennCare	MH/SUD PIHP	1115(a)
TEXAS	STAR	PCCM Provider	1915(b)
UTAH	Primary Care Network (PCN)	PCCM Provider	1115(a)
VERMONT	Global Commitment to Health	MCO (Comprehensive Benefits)	1115(a)

*Managed Care Entity Type is "Other".

Medicaid Program that include Pharmacy services as of June 30, 2006

State	Program Name	Managed Care Entity Type	Operating Authority
VIRGINIA	MEDALLION/Medallion II	MCO (Comprehensive Benefits)	1915(b)
VIRGINIA	MEDALLION/Medallion II	PCCM Provider	1915(b)
WASHINGTON	Healthy Options	MCO (Comprehensive Benefits)	1932(a)
WASHINGTON	Healthy Options	PCCM Provider	1932(a)
WASHINGTON	Medicare/Medicaid Integration Partnership (MMIP)	MCO (Comprehensive Benefits)	1932(a)
WASHINGTON	Washington Medicaid Integration Partnership (WMIP)	MCO (Comprehensive Benefits)	1932(a)
WISCONSIN	BadgerCare [SCHIP]	MCO (Comprehensive Benefits)	1115(a)
WISCONSIN	Medicaid HMO Program	MCO (Comprehensive Benefits)	1932(a)
WISCONSIN	Medicaid SSI Managed Care Program	MCO (Comprehensive Benefits)	1932(a)
WISCONSIN	Wisconsin Partnership Program	MCO (Comprehensive Benefits)	1115(a)

Medicaid Programs that Enroll Adults as of June 30, 2006

State	Program Name	Aged Adults	Blind/Disabled Adults	Section 1931 (AFDC/TANF) Adults	Managed Care Entity	Operating Authority
AL	Maternity Care Program			x	Medical-only PIHP	1915(b)
AL	Partnership Hospital Program	x	x	x	Medical-only PIHP	1915(a), voluntary
AL	Patient 1st	x	x	x	PCCM Provider	1915(b)
AK	Non-Emergency Transportation	x	x	x	*FFS Transportation Broker	1915(b)
AR	Non-Emergency Transportation	x	x	x	Transportation PAHP	1915(b)
AR	Primary Care Physician	x	x	x	PCCM Provider	1915(b)
AZ	Arizona Health Care Cost Containment System (AHCCCS)	x	x	x	MCO (Comprehensive Benefits)	1115(a)
AZ	Arizona Health Care Cost Containment System (AHCCCS)	x	x	x	MH/SUD PIHP	1115(a)
CA	AIDS Healthcare Foundation	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
CA	Caloptima	x	x	x	HIO	1915(b)
CA	Central Coast Alliance for Health	x	x	x	HIO	1915(b)
CA	Family Mosaic		x		*Emotional and Mental Health Support PIHP	1915(a), voluntary
CA	Health Plan of San Mateo	x	x	x	MCO/COHS	1915(b)
CA	Medi-Cal Specialty Mental Health Services Consolidation	x	x	x	Mental health plans	1915(b)
CA	Partnership Health Plan of California		x	x	HIO	1915(b)
CA	Prepaid Health Plan Program	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
CA	Prepaid Health Plan Program	x	x	x	Dental PAHP	1915(a), voluntary
CA	Sacramento Geographic Managed Care (CCS/Dental)	x	x	x	MCO (Comprehensive Benefits)	1932(a)/1915(b)
CA	Sacramento Geographic Managed Care (CCS/Dental)	x	x	x	Dental PAHP	1932(a)/1915(b)
CA	San Diego Geographic Managed Care	x	x	x	MCO (Comprehensive Benefits)	1932(a)/1915(b)
CA	Santa Barbara Health Initiative	x	x	x	HIO	1915(b)
CA	Senior Care Action Network	x	x		*Social HMO	1115(a)
CA	Two-Plan Model Program	x	x		MCO (Comprehensive Benefits)	1932(a)/1915(b)
CO	Colorado Medicaid Community Mental Health Services Program	x	x	x	Mental Health (MH) PIHP	1915(b)
CO	Managed Care Program	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
CO	Managed Care Program	x	x	x	Medical-only PIHP	1915(a), voluntary
CO	Primary Care Physician Program	x	x	x	PCCM Provider	1905(t)
CT	HUSKY A			x	MCO (Comprehensive Benefits)	1915(b)
DE	Delaware Physicians Care , Inc.		x	x	MCO (Comprehensive Benefits)	1115(a)
DE	Diamond State Partners		x	x	*Enhanced Fee for Service Model	1115(a)
DC	District of Columbia Medicaid Managed Care Program			x	MCO (Comprehensive Benefits)	1932(a)
FL	Comprehensive Adult Day Health Care Program	x			*Adult Day Health Care Facility	1915(b)/(c)
FL	Florida Coordinated Non-Emergency Transportation	x	x	x	Transportation PAHP	1915(b)
FL	Managed Health Care	x	x	x	*Hospital Based Network PIHP	1915(b)
FL	Managed Health Care	x	x	x	Disease Management PAHP	1915(b)
FL	Managed Health Care	x	x	x	PCCM Provider	1915(b)
FL	Managed Health Care		x		MCO (Comprehensive Benefits)	1915(b)
FL	Managed Health Care	x	x	x	Dental PAHP	1915(b)
FL	Medicaid Alzheimers Waiver Program	x			*Community Care for the Elderly	1915(b)/(c)

*Managed Care Entity Type is considered "Other".

Medicaid Programs that Enroll Adults as of June 30, 2006

State	Program Name	Aged Adults	Blind/Disabled Adults	Section 1931 (AFDC/TANF) Adults	Managed Care Entity	Operating Authority
FL	Prepaid Mental Health Plan	x	x	x	Mental Health (MH) PIHP	1915(b)
GA	Georgia Better Health Care		x	x	PCCM Provider	1932(a)
GA	Georgia Healthy Families			x	MCO (Comprehensive Benefits)	1932(a)
GA	Non-Emergency Transportation Broker Program	x	x	x	Transportation PAHP	1915(b)
GA	Preadmission Screening and Annual Resident Review (PASARR)	x	x		Mental Health (MH) PIHP	1915(b)
HI	Hawaii QUEST			x	MCO (Comprehensive Benefits)	1115(a)
HI	Hawaii QUEST	x	x	x	MH/SUD PIHP	1115(a)
ID	Healthy Connections	x	x	x	PCCM Provider	1915(b)
IL	Voluntary Managed Care			x	MCO (Comprehensive Benefits)	1915(a), voluntary
IN	Hoosier Healthwise			x	MCO (Comprehensive Benefits)	1915(b)
IN	Medicaid Select	x	x		PCCM Provider	1915(b)
IA	Iowa Medicaid Managed Health Care			x	MCO (Comprehensive Benefits)	1932(a)
IA	Iowa Medicaid Managed Health Care			x	PCCM Provider	1932(a)
IA	Iowa Plan For Behavioral Health		x	x	MH/SUD PIHP	1915(b)
KS	HealthConnect Kansas		x	x	PCCM Provider	1932(a)
KS	HealthWave 19			x	MCO (Comprehensive Benefits)	1932(a)
KY	Human Service Transportation	x	x	x	Transportation PAHP	1915(b)
KY	Kentucky Health Care Partnership Program	x	x	x	MCO (Comprehensive Benefits)	1115(a)
KY	Kentucky Patient Access and Care (KENPAC) Program			x	PCCM Provider	1932(a)
LA	Community Care		x	x	PCCM Provider	1932(a)
ME	MaineCare Primary Care Case Management			x	PCCM Provider	1932(a)
MD	HealthChoice		x	x	MCO (Comprehensive Benefits)	1115(a)
MA	Mass Health		x	x	PCCM Provider	1115(a)
MA	Mass Health		x	x	MH/SUD PIHP	1115(a)
MA	Mass Health		x	x	MCO (Comprehensive Benefits)	1115(a)
MI	Comprehensive Health Plan	x	x	x	MCO (Comprehensive Benefits)	1915(b)
MI	Specialty Prepaid Inpatient Health Plans	x	x	x	MH/SUD PIHP	1915(b)/(c)
MN	Consolidated Chemical Dependency Treatment Fund	x		x	*County Case Manager	1915(b)
MN	Minnesota Disability Health Options (MnDHO)		x		MCO (Comprehensive Benefits)	1915(a), voluntary
MN	Minnesota Prepaid Medical Assistance Program	x		x	MCO (Comprehensive Benefits)	1932(a)
MN	Minnesota Senior Care/Minnesota Senior Care Plus	x	x		MCO (Comprehensive Benefits)	1915(b)/(c)
MO	MC+ Managed Care/1915b			x	MCO (Comprehensive Benefits)	1915(b)
MO	MC+ Managed Care/1915b	x	x	x	Transportation PAHP	1915(b)
MS	Disease Management Program	x	x	x	Disease Management PAHP	1915(a), voluntary
MT	Montana Passport to Health	x	x	x	PCCM Provider	1915(b)
MT	Passport To Health	x	x	x	PCCM Provider	1915(b)
NE	Nebraska Health Connection Combined Waiver Program	x	x	x	*Specialty Physician Case Management	1915(b)
NE	Nebraska Health Connection Combined Waiver Program	x	x	x	PCCM Provider	1932(a)
NE	Nebraska Health Connection Combined Waiver Program	x	x	x	MCO (Comprehensive Benefits)	1932(a)

*Managed Care Entity Type is considered "Other".

Medicaid Programs that Enroll Adults as of June 30, 2006

State	Program Name	Aged Adults	Blind/Disabled Adults	Section 1931 (AFDC/TANF) Adults	Managed Care Entity	Operating Authority
NV	Mandatory Health Maintenance Program			x	MCO (Comprehensive Benefits)	1932(a)
NV	Mandatory Non-Emergency Transportation Broker Program	x	x	x	Transportation PAHP	1932(a)
NH	New Hampshire Medicaid Health Management Program		x		Disease Management PAHP	1915(b)
NJ	NJ FamilyCare - 1915(b)	x			MCO (Comprehensive Benefits)	1915(b)
NJ	NJ FamilyCare - 1932 (a)	x	x	x	MCO (Comprehensive Benefits)	1932(a)
NM	NEW MEXICO SALUD!	x	x	x	MCO (Comprehensive Benefits)	1915(b)
NM	NEW MEXICO SALUD!		x	x	Mental Health (MH) PIHP	1915(b)
NY	Managed Long Term Care Program		x		Long Term Care PIHP	1915(a), voluntary
NY	Office of Mental Health/Partial Capitation Program	x	x	x	Mental Health (MH) PAHP	1915(a), voluntary
NY	Partnership Plan Medicaid Managed Care Program		x	x	MCO (Comprehensive Benefits)	1115(a)
NY	Partnership Plan Medicaid Managed Care Program	x	x	x	PCCM Provider - Fee For Service	1115(a)
NY	Partnership Plan Medicaid Managed Care Program	x	x	x	PCCM Provider - Risk Based Capitation	1115(a)
NC	Carolina ACCESS	x	x	x	PCCM Provider	1932(a)
NC	Community Care of North Carolina (ACCESS II/III)	x	x	x	PCCM Provider	1932(a)
NC	Health Care Connection	x	x	x	MCO (Comprehensive Benefits)	1932(a)
NC	Piedmont Cardinal Health Plan (Innovations)	x	x		MH/SUD PIHP	1915(b)/(c)
ND	North Dakota Medicaid Managed Care Program			x	PCCM Provider	1932(a)
ND	North Dakota Medicaid Managed Care Program			x	MCO (Comprehensive Benefits)	1932(a)
OH	State Plan Amendment for Ohio's Full-Risk Managed Care Program			x	MCO (Comprehensive Benefits)	1932(a)
OK	Non-Emergency Transportation	x	x	x	Transportation PAHP	1932(a)
OK	SoonerCare	x	x	x	Medical-only PAHP	1115(a)
OR	Non-Emergency Transportation	x	x	x	*FFS Transportation Brokers	1915(b)
OR	Oregon Health Plan	x	x	x	MH/SUD PIHP	1115(a)
OR	Oregon Health Plan	x	x	x	PCCM Provider	1115(a)
OR	Oregon Health Plan	x	x	x	Dental PAHP	1115(a)
OR	Oregon Health Plan	x	x	x	MCO (Comprehensive Benefits)	1115(a)
PA	Access Plus Program	x	x	x	PCCM Provider	1915(b)
PA	Access Plus Program	x	x	x	Disease Management PAHP	1915(b)
PA	HealthChoices	x	x	x	MCO (Comprehensive Benefits)	1915(b)
PA	HealthChoices	x	x	x	MH/SUD PIHP	1915(b)
PA	Long Term Care Capitated Assistance Program (PIHP)	x	x		Medical-only PIHP	1915(a), voluntary
PA	Voluntary HMO Contracts	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
PR	Puerto Rico Health Care Plan	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
PR	Puerto Rico Health Care Plan	x	x	x	MH/SUD PIHP	1915(a), voluntary
RI	Rite Care			x	MCO (Comprehensive Benefits)	1115(a)
SC	Health Maintenance Organization (HMO)		x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
SC	Medical Homes Network	x	x	x	PCCM Provider	1905(t)
SC	Physicians Enhanced Program (PEP)		x	x	Medical-only PAHP	1915(a), voluntary
SD	Dental Program	x	x	x	Dental PAHP	1915(a), voluntary

*Managed Care Entity Type is considered "Other".

Medicaid Programs that Enroll Adults as of June 30, 2006

State	Program Name	Aged Adults	Blind/Disabled Adults	Section 1931 (AFDC/TANF) Adults	Managed Care Entity	Operating Authority
SD	PRIME		x	x	PCCM Provider	1932(a)
TN	TennCare	x	x	x	MCO (Comprehensive Benefits)	1115(a)
TN	TennCare	x	x	x	MH/SUD PIHP	1115(a)
TN	TennCare	x	x		Pharmacy Benefit Manager	1115(a)
TX	NorthSTAR	x	x	x	MH/SUD PIHP	1915(b)
TX	STAR		x	x	PCCM Provider	1915(b)
TX	STAR		x	x	MCO (Comprehensive Benefits)	1915(b)
TX	STAR+PLUS	x	x		MCO (Comprehensive Benefits)	1915(b)/(c)
UT	Choice Of Health Care Delivery	x	x	x	Medical-only PIHP	1915(b)
UT	Choice Of Health Care Delivery	x	x		PCCM Provider	1915(b)
UT	Non-Emergency Transportation	x	x	x	Transportation PAHP	1915(b)
UT	Prepaid Mental Health Program	x	x	x	Mental Health (MH) PIHP	1915(b)
UT	Primary Care Network (PCN)			x	Mental Health (MH) PIHP	1115(a)
UT	Primary Care Network (PCN)			x	Medical-only PIHP	1115(a)
UT	Primary Care Network (PCN)			x	PCCM Provider	1115(a)
VT	Global Commitment to Health	x	x	x	MCO (Comprehensive Benefits)	1115(a)
VA	MEDALLION/Medallion II	x	x	x	PCCM Provider	1915(b)
VA	MEDALLION/Medallion II	x	x	x	MCO (Comprehensive Benefits)	1915(b)
VA	Virginia Non-Emergency Transportation Services	x	x	x	Transportation PAHP	1915(b)
WA	Healthy Options			x	MCO (Comprehensive Benefits)	1932(a)
WA	Medicare/Medicaid Integration Partnership (MMIP)	x	x		MCO (Comprehensive Benefits)	1932(a)
WA	The Integrated Mental Health Services	x	x	x	Mental Health (MH) PIHP	1915(b)
WA	Washington Medicaid Integration Partnership (WMIP)	x	x		MCO (Comprehensive Benefits)	1932(a)
WV	Mountain Health Trust			x	MCO (Comprehensive Benefits)	1915(b)
WV	Mountain Health Trust		x	x	PCCM Provider	1915(b)
WI	Family Care	x	x		Long Term Care PIHP	1915(b)/(c)
WI	Medicaid HMO Program			x	MCO (Comprehensive Benefits)	1932(a)
WI	Medicaid SSI Managed Care Program		x		MCO (Comprehensive Benefits)	1932(a)
WI	Wisconsin Partnership Program		x		MCO (Comprehensive Benefits)	1115(a)

*Managed Care Entity Type is considered "Other".

Medicaid Programs that Enroll Children as of June 30, 2006

State	Program Name	Foster Care Children	Section 1931 (AFDC/TANF) Children	Blind/Disabled Children	Managed Care Entity Type	Operating Authority
AK	Non-Emergency Transportation	X	X	X	FFS Transportation Brokers*	1915(b)
AL	Maternity Care Program		X		Medical-only PIHP	1915(b)
AL	Partnership Hospital Program		X	X	Medical-only PIHP	1915(a), voluntary
AL	Patient 1st		X	X	PCCM	1915(b)
AR	Non-Emergency Transportation	X	X	X	Transportation PAHP	1915(b)
AR	Primary Care Physician	X	X	X	PCCM	1915(b)
AZ	Arizona Health Care Cost Containment System (AHCCCS)	X	X	X	MCO	1115(a)
AZ	Arizona Health Care Cost Containment System (AHCCCS)	X	X	X	MH/SUD PIHP	1115(a)
CA	AIDS Healthcare Foundation	X	X	X	MCO	1915(a)
CA	Caloptima	X	X	X	HIO	1915(b)
CA	Central Coast Alliance for Health	X	X	X	HIO	1915(b)
CA	Family Mosiac	X	X		Emotional and Mental Health Support PIHP*	1915(a), voluntary
CA	Health Plan of San Mateo	X	X	X	MCO/COHS	1915(b)
CA	Medi-Cal Specialty Mental Health Services Consolidation		X	X	Mental health plans*	1915(b)
CA	Partnership Health Plan of California	X	X	X	HIO	1915(b)
CA	Prepaid Health Plan Program	X	X	X	Dental PAHP	1915(a), voluntary
CA	Prepaid Health Plan Program	X	X	X	MCO	1915(a), voluntary
CA	Sacramento Geographic Managed Care(CCS/Dental)	X	X	X	Dental PAHP	1915(b)/1932(a)
CA	Sacramento Geographic Managed Care(CSS/Dental)	X	X	X	MCO	1915(b)/1932(a)
CA	San Diego Geographic Managed Care	X	X	X	MCO	1915(b)/1932(a)
CA	Santa Barbara Health Initiative	X	X	X	HIO	1915(b)
CA	Two-Plan Model Program	X	X	X	MCO	1915(b)/1932(a)
CO	Colorado Medicaid Community Mental Health Services	X	X	X	Mental Health (MH) PIHP	1915(b)
CO	Managed Care Program		X	X	MCO	1915(a), voluntary
CO	Managed Care Program		X	X	Medical-only PIHP	1915(a), voluntary
CO	Primary Care Physician Program		X	X	PCCM	1905(t)
CT	HUSKY A	X	X		MCO	1915(b)
DC	District of Columbia Medicaid Managed Care Program		X		MCO	1932(a)
DC	Health Services for Children with Special Needs		X		Medical-only PIHP	1915(a), voluntary
DE	Delaware Physicians Care , Inc.	X	X	X	MCO	1115(a)
DE	Diamond State Partners	X	X	X	Enhanced Fee for Service Model*	1115(a)
FL	Florida Coordinated Non-Emergency Transportation	X	X	X	Transportation PAHP	1915(b)
FL	Managed Health Care	X	X	X	Dental PAHP	1915(b)
FL	Managed Health Care	X	X	X	Disease Management PAHP	1915(b)
FL	Managed Health Care	X	X	X	MCO	1915(b)
FL	Managed Health Care	X	X	X	PCCM	1915(b)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Children as of June 30, 2006

State	Program Name	Foster Care Children	Section 1931 (AFDC/TANF) Children	Blind/Disabled Children	Managed Care Entity Type	Operating Authority
FL	Managed Health Care	X	X	X	Hospital Based Network PIHP*	1915(b)
FL	Prepaid Mental Health Plan	X	X	X	Mental Health (MH) PIHP	1915(b)
GA	Georgia Better Health Care		X	X	PCCM	1932(a)
GA	Georgia Healthy Families		X		MCO	1932(a)
GA	Non-Emergency Transportation Broker Program		X	X	Transportation PAHP	1915(b)
HI	Hawaii QUEST	X	X		MCO	1115(a)
IA	Iowa Medicaid Managed Health Care		X		MCO	1932(a)
IA	Iowa Medicaid Managed Health Care		X		PCCM	1932(a)
IA	Iowa Plan For Behavioral Health	X	X	X	MH/SUD PIHP	1915(b)
ID	Healthy Connections	X	X	X	PCCM	1915(b)
IL	Voluntary Managed Care		X		MCO	1915(a), voluntary
IN	Hoosier Healthwise	X	X		MCO	1915(b)
IN	Medicaid Select			X	PCCM	1915(b)
KS	HealthConnect Kansas		X	X	PCCM	1932(a)
KS	HealthWave 19		X		MCO	1932(a)
KY	Human Service Transportation	X	X	X	Transportation PAHP	1915(b)
KY	Kentucky Health Care Partnership Program	X	X	X	MCO	1115(a)
KY	Kentucky Patient Access and Care (KENPAC) Program		X		PCCM	1932(a)
LA	Community Care		X	X	PCCM	1932(a)
MA	Mass Health	X	X	X	MCO	1115(a)
MA	Mass Health	X	X	X	MH/SUD PIHP	1115(a)
MA	Mass Health	X	X	X	PCCM	1115(a)
MD	HealthChoice	X	X	X	MCO	1115(a)
ME	MaineCare Primary Care Case Management	X	X		PCCM	1932(a)
MI	Comprehensive Health Plan		X	X	MCO	1915(b)
MI	Specialty Prepaid Inpatient Health Plans	X	X	X	MH/SUD PIHP	1915b/c
MN	Consolidated Chemical Dependency Treatment Fund	X	X		County Case Manager*	1915(b)
MN	Minnesota Prepaid Medical Assistance Program-1932(a)	X	X		MCO	1115(a)
MO	MC+ Managed Care/1915b	X	X		MCO	1915(b)
MO	MC+ Managed Care/1915b	X	X	X	Transportation PAHP	1915(b)
MS	Disease Management Program	X	X	X	Disease Management PAHP	1915(a), voluntary
MT	Montana Passport To Health	X	X	X	PCCM	1915(b)
NC	Carolina ACCESS	X	X	X	PCCM	1932(a)
NC	Community Care of North Carolina (ACCESS II/III)	X	X	X	PCCM	1932(a)
NC	Health Care Connection	X	X	X	MCO	1932(a)
NC	Piedmont Cardinal Health Plan (Innovations)	X		X	MH/SUD PIHP	1915b/c

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Children as of June 30, 2006

State	Program Name	Foster Care Children	Section 1931 (AFDC/TANF) Children	Blind/Disabled Children	Managed Care Entity Type	Operating Authority
ND	North Dakota Access and Care Program		X		MCO	1932(a)
ND	North Dakota Access and Care Program		X		PCCM	1932(a)
NE	1915(b)		X		Specialty Physician Case Management*	1915(b)
NE	Nebraska Health Connection Combined Waiver Program-		X		MCO (Comprehensive Benefits)	1932(a)
NE	1932(a)		X		PCCM	1932(a)
NH	New Hampshire Medicaid Disease Management Program	X	X		Disease Management PAHP	1915(b)
NJ	NJ FamilyCare - 1915(b)	X		X	MCO	1915(b)
NJ	NJ FamilyCare - 1932(a)	X	X		MCO	1932(a)
NM	NEW MEXICO SALUD!	X	X	X	MCO	1915(b)
NM	NEW MEXICO SALUD!	X	X	X	Mental Health (MH) PIHP	1915(b)
NV	Mandatory Health Maintenance Program		X		MCO	1932(a)
NV	Mandatory Non-Emergency Transportation Broker Program	X	X	X	Transportation PAHP	1932(a)
NY	Office of Mental Health/Partial Capitation Program		X	X	Mental Health (MH) PAHP	1915(a), voluntary
NY	Partnership Plan Medicaid Managed Care Program	X	X	X	MCO	1115(a)
NY	Partnership Plan Medicaid Managed Care Program	X	X	X	PCCM-FFS	1115(a)
NY	Partnership Plan Medicaid Managed Care Program	X	X	X	PCCM-Risk Based Capitation	1115(a)
OH	State Plan Amendment for Ohio's Full Risk Managed Care	X	X		MCO	1932(a)
OK	Non-Emergency Transportation	X	X	X	Transportation PAHP	1932(a)
OK	SoonerCare		X	X	Medical-only PAHP	1115(a)
OR	Non-Emergency Transportation		X	X	FFS Transportation Brokers*	1915(b)
OR	Oregon Health Plan		X	X	Dental PAHP	1115(a)
OR	Oregon Health Plan		X	X	MCO	1115(a)
OR	Oregon Health Plan	X	X	X	MH/SUD PIHP	1115(a)
OR	Oregon Health Plan	X	X	X	PCCM	1115(a)
PA	Access Plus Program	X	X	X	Disease Management PAHP	1915(b)
PA	Access Plus Program	X	X	X	PCCM	1915(b)
PA	HealthChoices	X	X	X	MCO	1915(b)
PA	HealthChoices	X	X	X	MH/SUD PIHP	1915(b)
PA	Voluntary HMO Contracts		X	X	MCO	1915(a), voluntary
PR	Puerto Rico Health Care Plan	X	X	X	MCO	1915(a), voluntary
PR	Puerto Rico Health Care Plan	X	X	X	MH/SUD PIHP	1915(a), voluntary
RI	Rite Care	X	X		MCO	1115(a)
SC	Health Maintenance Organization (HMO)		X	X	MCO	1915(a), voluntary
SC	Medical Homes Network	X	X	X	PCCM	1905(t)
SC	Medically Fragile Children Program (MFCP)	X	X	X	Medical-only PAHP	1915(a) , Voluntary

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Children as of June 30, 2006

State	Program Name	Foster Care Children	Section 1931 (AFDC/TANF) Children	Blind/Disabled Children	Managed Care Entity Type	Operating Authority
SC	Physicians Enhanced Program (PEP)	X	X	X	Medical-only PAHP	1915(a), voluntary
SD	Dental Program	X	X	X	Dental PAHP	1915(a), voluntary
SD	PRIME		X		PCCM	1932(a)
TN	TennCare	X	X	X	MCO	1115(a)
TN	TennCare	X	X	X	MH/SUD PIHP	1115(a)
TN	TennCare	X		X	Pharmacy Benefit Manager*	1115(a)
TX	NorthSTAR		X	X	MH/SUD PIHP	1915(b)
TX	STAR		X	X	MCO	1915(b)
TX	STAR		X	X	PCCM	1915(b)
TX	STAR+PLUS			X	MCO	1915b/c
TX	STAR+PLUS		X		PCCM	1915b/c
UT	Choice Of Health Care Delivery	X	X	X	Medical-only PIHP	1915(b)
UT	Choice Of Health Care Delivery	X	X	X	PCCM	1915(b)
UT	Non-Emergency Transportation	X	X	X	Transportation PAHP	1915(b)
UT	Prepaid Mental Health Program	X	X	X	Mental Health (MH) PIHP	1915(b)
VA	MEDALLION/Medallion II		X	X	PCCM	1915(b)
VA	MEDALLION/Medallion II		X	X	MCO	1915(b)
VA	Virginia Non-Emergency Transportation Services	X	X	X	Transportation PAHP	1915(b)
VT	Global Commitment to Health	X	X	X	MCO	1115(a)
WA	Disease Management Program	X	X	X	Disease Management PAHP	1915(b)
WA	Healthy Options		X		MCO	1932(a)
WA	The Integrated Mental Health Services	X	X	X	Mental Health (MH) PIHP	1915(b)
WI	Children Come First (CCF)	X	X	X	MH/SUD PIHP	1915(a), voluntary
WI	Medicaid HMO Program		X		MCO	1932(a)
WI	Wraparound Milwaukee	X	X	X	MH/SUD PIHP	1915(a), voluntary
WV	Mountain Health Trust		X		MCO	1915(b)
WV	Mountain Health Trust	X	X	X	PCCM	1915(b)

*Indicates MCE Type is "Other".

State that Incoporate SCHIP into their Medicaid Programs as of June 30,2006

State	Program Name	Managed Care Entity Type	Operating Authority
AK	Non-Emergency Transportation	FFS Transportation Broker*	1915(b)
AR	Non-Emergency Transportation	Transportation PAHP	1915(b)
AR	Primary Care Physician	PCCM Provider	1915(b)
CA	Health Plan of San Mateo	MCO/COHS	1915(b)
DC	District of Columbia Medicaid Managed Care Program	MCO	1932(a)
DC	Health Services for Children with Special Needs	Medical-only PIHP	1915(a), voluntary
DE	Diamond State Partners	Fee-For-Service Model*	1115(a)
DE	Delaware Physicians Care, Inc.	MCO	1115(a)
FL	Florida Coordinated Non-Emergency Transportation	Transportation PAHP	1915(b)
FL	Managed Health Care	Dental PAHP	1915(b)
FL	Managed Health Care	Disease Management PAHP	1915(b)
FL	Managed Health Care	Hospital Based Network PIHP*	1915(b)
FL	Managed Health Care	MCO	1915(b)
FL	Managed Health Care	PCCM	1915(b)
GA	Georgia Healthy Families	MCO	1932(a)
HI	Hawaii QUEST	MCO	1115(a)
ID	Healthy Connections	PCCM	1915(b)
IL	Voluntary Managed Care	MCO	1915(a), voluntary
IN	Hoosier Healthwise	MCO	1915(b)
KY	Human Service Transportation	Transportation PAHP	1915(b)
KY	Kentucky Health Care Partnership Program	MCO	1115(a)
KY	Kentucky Patient Access and Care (KENPAC) Program	PCCM	1932(a)
LA	Community Care	PCCM	1932(a)
MA	Mass Health	MCO	1115(a)
MA	Mass Health	MH/SUD PIHP	1115(a)
MA	Mass Health	PCCM	1115(a)
MD	HealthChoice	MCO	1115(a)
ME	MaineCare Primary Care Case Management	PCCM	1932(a)
MN	Consolidated Chemical Dependency Treatment Fund	County Case Manager*	1915(b)
MN	Minnesota Prepaid Medical Assistance Program-1932(a)	MCO	1932(a)
MN	MinnesotaCare Program For Families And Children	MCO	1115(a)
MO	MC+ Managed Care/1115	MCO	1115(a)
NE	Nebraska Health Connection Combined Waiver Program	Specialty Physician Case Management (SPCM) Program*	1915(b)
NE	Nebraska Health Connection Combined Waiver Program	MCO	1932(a)
NE	Nebraska Health Connection Combined Waiver Program	PCCM	1932(a)
NJ	NJ FamilyCare - 1932 (a)	MCO	1932(a)
NM	NEW MEXICO SALUD!	MCO	1915(b)
NM	NEW MEXICO SALUD!	Mental Health (MH) PIHP	1915(b)
NV	Mandatory Non-Emergency Transportation Broker Program	Transportation PAHP	1932(a)
OH	State Plan Amendment for Ohio's Full-Risk Managed Care Program	MCO	1932(a)
OK	Non-Emergency Transportation	Transportation PAHP	1932(a)
OK	SoonerCare	Medical-only PAHP	1115(a)
OR	Non-Emergency Transportation	FFS Transportation Brokers*	1915(b)
OR	Oregon Health Plan	Dental PAHP	1115(a)
OR	Oregon Health Plan	MCO	1115(a)
OR	Oregon Health Plan	MH/SUD PIHP	1115(a)

*Managed Care Entity Type is "Other".

State that Incoporate SCHIP into their Medicaid Programs as of June 30,2006

State	Program Name	Managed Care Entity Type	Operating Authority
OR	Oregon Health Plan	PCCM	1115(a)
PR	Puerto Rico Health Care Plan	MCO	1915(a), voluntary
PR	Puerto Rico Health Care Plan	MH/SUD PIHP	1915(a), voluntary
RI	Rite Care	MCO	1115(a)
SC	Medical Homes Network	PCCM	1907(t)
SC	Physicians Enhanced Program (PEP)	Medical-only PAHP	1915(a), voluntary
SD	Dental Program	Dental PAHP	1915(a), voluntary
SD	PRIME	PCCM	1932(a)
TN	TennCare	MCO	1115(a)
VA	MEDALLION/Medallion II	MCO	1915(b)
VA	MEDALLION/Medallion II	PCCM	1915(b)
VA	Virginia Non-Emergency Transportation Services	Transportation PAHP	1915(b)
WA	Healthy Options	PCCM	1932(a)
WI	BadgerCare [SCHIP]	MCO	1115(a)
WI	Children Come First (CCF)	MH/SUD PIHP	1915(a), voluntary
WI	Wraparound Milwaukee	MH/SUD PIHP	1915(a), voluntary

*Managed Care Entity Type is "Other".

Medicaid Programs that Enroll Special Needs Children as of June 30, 2006

State	Program Name	Special Needs Children (State Defined)	Special Needs Children (BBA Defined)	Managed Care Entity Type	Operating Authority
AK	Non-Emergency Transportation	X	X	FFS Transportation Broker*	1915(b)
AR	Non-Emergency Transportation	X		Transportation PAHP	1915(b)
CO	Colorado Medicaid Community Mental Health Services		X	Mental Health (MH) PIHP	1915(b)
DC	District of Columbia Medicaid Managed Care Program	X		MCO	1932(a)
DC	Health Services for Children with Special Needs	X		Medical-only PIHP	1915(a), voluntary
DE	Delaware Physicians Care , Inc.	X	X	MCO	1115(a)
DE	Diamond State Partners		X	Enhanced Fee for Service Model*	1115(a)
FL	Florida Coordinated Non-Emergency Transportation	X	X	Transportation PAHP	1915(b)
IL	Voluntary Managed Care		X	MCO	1915(a), voluntary
KS	Health Connect Kansas		X	PCCM	1932(a)
KS	HealthWave19		X	PCCM	1932(a)
MA	Mass Health		X	PCCM	1115(a)
MN	Consolidated Chemical Dependency Treatment Fund		X	County Case Manager*	1915(b)
MN	Minnesota Prepaid Medical Assistance Program		X	MCO	1115(a)
MO	MC+ Managed Care/1915b	X		MCO	1915(b)
MT	Montana Passport To Health		X	PCCM	1915(b)
MS	Disease Management Program	X	X	Disease Management PAHP	1915(a), voluntary
NC	Carolina ACCESS		X	PCCM	1932(a)
NC	Community Care of North Carolina (ACCESS II/III)		X	PCCM	1932(a)
NC	Health Care Connection		X	MCO	1932(a)
NJ	NJ FamilyCare - 1915(b)		X	MCO	1915(b)
NE	1915(b)	X		Specialty Physician Case Management*	1915(b)
NE	Nebraska Health Connection Combined Waiver Program-	X		MCO	1932(a)
NE	1915(b)	X		PCCM Provider	1932(a)
NM	NEW MEXICO SALUD!	X	X	Mental Health (MH) PIHP	1915(b)
NV	Mandatory Health Maintenance Program	X		MCO	1932(a)
NV	Mandatory Non-Emergency Transportation		X	Transportation PAHP	1915(b)
OH	State Plan Amendment for Ohio's Full-Risk Managed Care	X	X	Disease Management PAHP	1932(a)
OK	Non-Emergency Transportation	X		Transportation PAHP	1932(a)
OR	Oregon Health Plan		X	MH/SUD PIHP	1115(a)
PA	Access Plus Program	X		Disease Management PAHP	1915(b)
PA	Access Plus Program	X		PCCM	1915(b)
PA	HealthChoices	X		MCO	1915(b)
PA	HealthChoices	X		MH/SUD PIHP	1915(b)
PA	Voluntary HMO Contracts	X		MCO	1915(a), voluntary

*Managed Care Entity Type is "Other".

Medicaid Programs that Enroll Special Needs Children as of June 30, 2006

State	Program Name	Special Needs Children (State Defined)	Special Needs Children (BBA Defined)	Managed Care Entity Type	Operating Authority
RI	Rite Care	X		MCO	1115(a)
SC	Medical Homes Network	X	X	PCCM	1905(t)
SC	Medically Fragile Children Program (MFCP)	X	X	Medical-only PAHP	1915(a), voluntary
UT	Choice Of Health Care Delivery	X		Medical-only PIHP	1915(b)
UT	Choice Of Health Care Delivery	X		PCCM	1915(b)
UT	Non-Emergency Transportation	X	X	Transportation PAHP	1915(b)
WA	Healthy Options	X		MCO	1932(a)

*Managed Care Entity Type is "Other".

Medicaid Programs that Enroll Dual Eligibles as of June 30, 2006

State	Program Name	QMB Plus, SLMB Plus, and Medicaid-only	QMB	SLMB, QI, and QDWI	Managed Care Entity Type	Operating Authority
Alaska	Non-Emergency Transportation	X	X	X	FFS Transportation Brokers*	1915(b)
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	X	X	X(QI)	MCO	1115(a)
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	X	X		MH/SUD PIHP	1115(a)
California	AIDS Healthcare Foundation	X			MCO	1915(a), voluntary
California	Caloptima	X			HIO	1915(b)
California	Central Coast Alliance for Health	X			HIO	1915(b)
California	Health Plan of San Mateo	X			MCO/COHS	1915(b)
California	Medi-Cal Specialty Mental Health Services Consolidation	X	X	X	Mental Health Plans*	1915(b)
California	Partnership Health Plan of California	X			HIO	1915(b)
California	Prepaid Health Plan Program	X			Dental PAHP	1915(a), voluntary
California	Prepaid Health Plan Program	X			MCO	1915(a), voluntary
California	Sacramento Geographic Managed Care	X			Dental PAHP	1915(b)/1932(a)
California	Sacramento Geographic Managed Care	X			MCO	1915(b)/1932(a)
California	San Diego Geographic Managed Care	X			MCO	1915(b)/1932(a)
California	Santa Barbara Health Initiative	X			HIO	1915(b)
California	Senior Care Action Network	X			Social HMO	1115(a)
California	Two-Plan Model Program	X			MCO	1915(b)/1932(a)
Colorado	Colorado Medicaid Community Mental Health	X			Mental Health PIHP	1915(b)
Colorado	Managed Care Program	X	X		MCO	1915(a), voluntary
Colorado	Primary Care Physician Program	X			PCCM	1915(t)
Florida	Managed Health Care	X	X	X	MCO	1915(b)
Florida	Managed Health Care	X	X	X	Dental PAHP	1915(b)
Florida	Managed Health Care	X	X	X	PCCM	1915(b)
Idaho	Healthy Connections	X			PCCM	1915(b)
Indiana	Medicaid Select	X			PCCM	1915(b)
Iowa	Iowa Plan For Behavioral Health	X	X	X	MH/SUD PIHP	1915(b)
Kentucky	Human Service Transportation	X		X	Transportation PAHP	1915(b)
Kentucky	Kentucky Health Care Partnership Program	X			MCO	1115(a)
Minnesota	Consolidated Chemical Dependency Treatment Fund	X			County Case Manager*	1915(b)
Minnesota	Minnesota Disability Health Options (MnDHO)	X			MCO	1915(a), voluntary

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Dual Eligibles as of June 30, 2006

State	Program Name	QMB Plus, SLMB Plus, and Medicaid-only	QMB	SLMB, QI, and QDWI	Managed Care Entity Type	Operating Authority
Minnesota	Minnesota Senior Health Options Program (MSHO)	X			MCO	1915(a), voluntary
Minnesota	Minnesota Prepaid Medical Assistance Program-	X			MCO	1115(a)
Minnesota	Minnesota Prepaid Medical Assistance Program-	X			MCO	1932(a)
Minnesota	Minnesota Senior Care/Minnesota Senior Care Plus	X			MCO	1915b/c
Mississippi	Disease Management Program	X			Disease Management PAHP	1915(a), voluntary
Nebraska	Nebraska Health Connection Combined Waiver	X	X	X	Specialty Physician Case	1915(b)
Nevada	Mandatory Non-Emergency Transportation Broker	X	X	X	Transportation PAHP	1932(a)
New Jersey	NJ FamilyCare-1915(b)	X			MCO	1915(b)
New Jersey	NJ FamilyCare-1932(a)	X			MCO	1932(a)
New York	Managed Long Term Care Program	X			LTC PIHP	1915(a), voluntary
New York	Non-Emergency Transportation	X			Transportation PAHP	1915(b)
New York	Office of Mental Health/Partial Capitation	X			Mental Health PAHP	1915(a), voluntary
New York	Partnership Plan - Medicaid Advantage	X	X (FULL MEDICAID COVERAGE)		MCO	1115(a)
New York	Partnership Plan Medicaid Managed Care	X			MCO	1115(a)
New York	Partnership Plan Medicaid Managed Care	X			PCCM-Risk Based Capitation	1115(a)
North Carolina	Community Care of North Carolina (Access II/III)	X (MEDICAID-ONLY)			PCCM	1932(a)
North Carolina	Carolina ACCESS 1932(a)	X (MEDICAID-ONLY)			PCCM	1932(a)
North Carolina	Piedmont Cardinal Health Plan (Innovations)	X			MH/SUD PIHP	1915b/c
Oklahoma	Non-Emergency Transportation	X	X		Transportation PAHP	1932(a)
Oregon	Oregon Health Plan	X			Dental PAHP	1115(a)
Oregon	Oregon Health Plan	X			MCO	1115(a)
Oregon	Oregon Health Plan	X			MH/SUD PIHP	1115(a)
Oregon	Oregon Health Plan	X			PCCM	1115(a)
Oregon	Non-Emergency Transportation	X	X	X	FFS Transportation Brokers*	1915(b)
Pennsylvania	Access Plus Program	X (UNDER 21)			PCCM	1915(b)
Pennsylvania	Access Plus Program	X (UNDER 21)			Disease Management PAHP	1915(b)
Pennsylvania	HealthChoices	X (UNDER 21)			MCO	1915(b)
Pennsylvania	HealthChoices	X			MH/SUD PIHP	1915(b)
Pennsylvania	Long Term Care Capitated Assistance Program	X	X	X	Medical-only PIHP	1915(a), voluntary

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Dual Eligibles as of June 30, 2006

State	Program Name	QMB Plus, SLMB Plus, and Medicaid-only	QMB	SLMB, QI, and QDWI	Managed Care Entity Type	Operating Authority
Pennsylvania	Voluntary HMO Contracts	X (UNDER 21)			MCO	1915(a), voluntary
Puerto Rico	Medicare Platino	X	X	X	MCO	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	X	X	X	MCO	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	X	X	X	MH/SUD PIHP	1915(a), voluntary
South Carolina	Medical Homes Network	X	X	X	PCCM	1905(t)
South Dakota	Dental Program	X	X		Dental PAHP	1915(a), voluntary
Tennessee	TennCare	X	X	X	MCO	1115(a)
Tennessee	TennCare	X	X	X	MH/SUD PIHP	1115(a)
Tennessee	TennCare	X	X	X	Dental Benefit Manager*	1115(a)
Tennessee	TennCare	X	X	X	Pharmacy Benefit Manager*	1115(a)
Texas	NorthSTAR	X (SSI&QMB PLUS)			MH/SUD PIHP	1915(b)
Texas	STAR+PLUS	X			PCCM	1915b/c
Texas	STAR+PLUS	X			MCO	1915b/c
Utah	Choice Of Health Care Delivery	X			Medical-only PIHP	1915(b)
Utah	Choice Of Health Care Delivery	X			PCCM	1915(b)
Utah	Non-Emergency Transportation	X			Transportation PAHP	1915(b)
Utah	Prepaid Mental Health Program	X			Mental Health PIHP	1915(b)
Utah	Primary Care Network (PCN)	X			Medical-only PIHP	1115(a)
Utah	Primary Care Network (PCN)	X			Mental Health PIHP	1115(a)
Utah	Primary Care Network (PCN)	X			PCCM	1115(a)
Vermont	Global Commitment to Health	X	X	X	MCO	1115(a)
Washington	Medicare/Medicaid Integration Partnership(MMIP)	X			MCO	1932(a)
Washington	The Integrated Mental Health Services	X			Mental Health PIHP	1915(b)
Washington	Washington Medicaid Integration Partnership	X			MCO	1932(a)
Wisconsin	Family Care	X	X	X	LTC PIHP	1915b/c
Wisconsin	Medicaid SSI Managed Care Program	X			MCO	1932(a)
Wisconsin	Wisconsin Partnership Program	X (QMB PLUS, SLMB PLUS)			MCO	1115(a)

*Indicates MCE Type is "Other".

Medicaid Programs that include American Indian/Alaskan Native Populations as of June 30, 2006

State	Program Name	Managed Care Entity Type	Operating Authority
AK	Non-Emergency Transportation	*FFS Transportation Broker	1915(b)
AL	Maternity Care Program	Medical-only PIHP	1915(b)
AL	Partnership Hospital Program	Medical-only PIHP	1915(a), voluntary
AL	Patient 1st	PCCM Provider	1915(b)
CA	Sacramento Georgraphic Managed Care (CCS/Dental)	MCO (Comprehensive Benefits)	1932(a), 1915(b)
CA	San Diego Geographic Managed Care	MCO (Comprehensive Benefits)	1932(a), 1915(b)
CO	Colorado Medicaid Community Mental Health Services Program	Mental Health (MH) PIHP	1915(b)
FL	Florida Coordinated Non-Emergency Transportation	Transportation PAHP	1915(b)
FL	Managed Health Care	Dental PAHP	1915(b)
IL	Voluntary Managed Care	MCO (Comprehensive Benefits)	1915(a), voluntary
IN	Hoosier Healthwise	MCO (Comprehensive Benefits)	1915(b)
KS	HealthConnect Kansas	PCCM Provider	1932(a)
KS	HealthWave 19	MCO (Comprehensive Benefits)	1932(a)
ME	MaineCare Primary Care Case Management	PCCM Provider	1932(a)
MN	Consolidated Chemical Dependency Treatment Fund	*County Case Manager	1915(b)
MN	Minnesota Prepaid Medical Assistance Program-1115(a)	MCO (Comprehensive Benefits)	1115(a)
NC	Carolina ACCESS	PCCM Provider	1932(a)
NC	Community Care of North Carolina (ACCESS II/III)	PCCM Provider	1932(a)
NC	Health Care Connection	MCO (Comprehensive Benefits)	1932(a)
NC	Piedmont Cardinal Health Plan (Innovations)	MH/SUD PIHP	1915(b)/(c)
NE	Nebraska Health Connection Combined Waiver Program - 1915(b)	*Specialty Physician Case Management	1915(b)
NE	Nebraska Health Connection Combined Waiver Program - 1915(b)	MCO (Comprehensive Benefits)	1915(b)
NE	Nebraska Health Connection Combined Waiver Program - 1915(b)	PCCM Provider	1915(b)
NM	NEW MEXICO SALUD!	MCO (Comprehensive Benefits)	1915(b)
NM	NEW MEXICO SALUD!	Mental Health (MH) PIHP	1915(b)
NV	**Mandatory Non-Emergency Transportation Broker Program	Transportation PAHP	1932(a)
NV	Mandatory Health Maintenance Program	MCO (Comprehensive Benefits)	1932(a)
OK	***SoonerCare	PCCM Provider	1115(a)
OK	SoonerCare	Medical-only PAHP	1115(a)
OR	Oregon Health Plan	MH/SUD PIHP	1115(a)
OR	Oregon Health Plan	PCCM Provider	1115(a)
PA	Access Plus Program	Disease Management PAHP	1915(b)
PA	Access Plus Program	PCCM Provider	1915(b)
SC	Medical Homes Network	PCCM Provider	1915(b)/(c)
SD	Dental Program	Dental PAHP	1915(a), voluntary
VA	MEDALLION/Medallion II	MCO (Comprehensive Benefits)	1915(b)
WA	***Healthy Options	PCCM Provider	1932(a)
WI	Medicaid SSI Managed Care Program	MCO (Comprehensive Benefits)	1932(a)

* Indicates the Managed Care Entity Type is "Other". **The Alaskan Native population is not included. ***PCCM is serves only the American Indian/Alaskan Native population.

Medicaid Programs that Include Mental Health Services as of June 30, 2006

State	Program Name	Managed Care Entity Type	Operating Authority	Inpatient MH	Outpatient MH
AL	Patient 1st	PCCM Provider	1915(b)	x	x
AZ	Arizona Health Care Cost Containment System (AHCCCS)	MCO (Comprehensive Benefits)	1115(a)	x	x
AZ	Arizona Health Care Cost Containment System (AHCCCS)	MH/SUD PIHP	1115(a)	x	x
CA	Family Mosaic	*Emotional and Mental Health Support PIHP	1915(a), voluntary	x	
CA	Medi-Cal Specialty Mental Health Services Consolidation	Mental health plans	1915(b)	x	x
CA	Partnership Health Plan of California	HIO	1915(b)	x	x
CA	Sacramento Geographic Managed Care (CCS/Dental)	MCO (Comprehensive Benefits)	1932(a)/1915(b)		x
CA	San Diego Geographic Managed Care	MCO (Comprehensive Benefits)	1932(a)		x
CO	Colorado Medicaid Community Mental Health Services Program	Mental Health (MH) PIHP	1915(b)	x	x
CT	HUSKY A	MCO (Comprehensive Benefits)	1915(b)	x	x
DC	District of Columbia Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1932(a)	x	x
DC	Health Services for Children with Special Needs	Medical-only PIHP	1915(a), voluntary	x	x
DE	Delaware Physicians Care , Inc.	MCO (Comprehensive Benefits)	1115(a)	x	x
DE	Diamond State Partners	*Enhanced Fee for Service Model	1115(a)	x	x
FL	Managed Health Care	PCCM Provider	1915(b)	x	
FL	Prepaid Mental Health Plan	Mental Health (MH) PIHP	1915(b)	x	x
GA	Georgia Better Health Care	PCCM Provider	1932(a)	x	
GA	Georgia Healthy Families	MCO (Comprehensive Benefits)	1932(a)	x	x
GA	Preadmission Screening and Annual Resident Review (PASAAR)	Mental Health (MH) PIHP	1915(b)	x	
HI	Hawaii QUEST	MCO (Comprehensive Benefits)	1115(a)	x	x
HI	Hawaii QUEST	MH/SUD PIHP	1115(a)	x	x
IA	Iowa Plan For Behavioral Health	MH/SUD PIHP	1915(b)	x	x
ID	Healthy Connections	PCCM Provider	1915(b)	x	x
IL	Voluntary Managed Care	MCO (Comprehensive Benefits)	1915(a), voluntary	x	x
IN	Medicaid Select	PCCM Provider	1915(b)		x
KS	HealthConnect Kansas	PCCM Provider	1932(a)	x	x
MA	Mass Health	MCO (Comprehensive Benefits)	1115(a)	x	x
MA	Mass Health	MH/SUD PIHP	1115(a)	x	x
MA	Mass Health	PCCM Provider	1115(a)	x	x
MI	Comprehensive Health Plan	MCO (Comprehensive Benefits)	1915(b)		x
MN	Minnesota Disability Health Options (MnDHO)	MCO (Comprehensive Benefits)	1915(a), voluntary	x	x
MN	Minnesota Prepaid Medical Assistance Program-1115(a)	MCO (Comprehensive Benefits)	1115(a)	x	x
MN	Minnesota Prepaid Medical Assistance Program-1932(a)	MCO (Comprehensive Benefits)	1932(a)	x	x
MN	Minnesota Senior Care/Minnesota Senior Care Plus	MCO (Comprehensive Benefits)	1915(b)/(c)	x	x
MN	Minnesota Senior Health Options Program (MSHO)	MCO (Comprehensive Benefits)	1915(a), voluntary	x	x
MN	MinnesotaCare Program For Families And Children	MCO (Comprehensive Benefits)	1115(a)	x	x
MO	MC+ Managed Care/1115	MCO (Comprehensive Benefits)	1115(a)	x	x
MO	MC+ Managed Care/1915b	MCO (Comprehensive Benefits)	1915(b)	x	x
MT	Montana Passport to Health	PCCM Provider	1915(b)	x	x
MT	Passport To Health	PCCM Provider	1915(b)	x	x
NC	Piedmont Cardinal Health Plan (Innovations)	MH/SUD PIHP	1915(b)/(c)	x	
ND	North Dakota Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1932(a)	x	x
ND	North Dakota Medicaid Managed Care Program	PCCM Provider	1932(a)	x	x

*Managed Care Entity Type is considered "Other".

Medicaid Programs that Include Mental Health Services as of June 30, 2006

State	Program Name	Managed Care Entity Type	Operating Authority	Inpatient MH	Outpatient MH
NE	Nebraska Health Connection Combined Waiver Program	*Specialty Physician Case Management	1915(b)	x	x
NJ	NJ FamilyCare - 1915(b)	MCO (Comprehensive Benefits)	1915(b)	x	x
NJ	NJ FamilyCare - 1932 (a)	MCO (Comprehensive Benefits)	1932(a)	x	x
NM	NEW MEXICO SALUD!	MCO (Comprehensive Benefits)	1915(b)	x	
NM	NEW MEXICO SALUD!	Mental Health PIHP	1915(b)	x	x
NV	Mandatory Health Maintenance Program	MCO (Comprehensive Benefits)	1932(a)	x	x
NY	Office of Mental Health/Partial Capitation Program	Mental Health (MH) PAHP	1915(a), voluntary		x
NY	Partnership Plan - Family Health Plus	*PPO (Comprehensive Benefits)	1115(a)	x	x
NY	Partnership Plan - Family Health Plus	MCO (Comprehensive Benefits)	1115(a)	x	x
NY	Partnership Plan - Medicaid Advantage	MCO (Comprehensive Benefits)	1115(a)	x	x
NY	Partnership Plan Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1115(a)	x	x
OH	State Plan Amendment for Ohio's Full-Risk Managed Care Program	MCO (Comprehensive Benefits)	1932(a)	x	x
OR	Oregon Health Plan	MCO (Comprehensive Benefits)	1115(a)	x	x
OR	Oregon Health Plan	MH/SUD PIHP	1115(a)	x	x
PA	Access Plus Program	PCCM Provider	1915(b)	x	x
PA	HealthChoices	MH/SUD PIHP	1915(b)	x	x
PR	Medicare Platino	MCO (Comprehensive Benefits)	1915(a), voluntary	x	x
PR	Puerto Rico Health Care Plan	MH/SUD PIHP	1915(a), voluntary	x	x
RI	Rite Care	MCO (Comprehensive Benefits)	1115(a)	x	x
SD	PRIME	PCCM Provider	1932(a)	x	x
TN	TennCare	MCO (Comprehensive Benefits)	1115(a)	x	x
TN	TennCare	MH/SUD PIHP	1115(a)	x	x
TX	NorthSTAR	MH/SUD PIHP	1915(b)	x	x
TX	STAR	MCO (Comprehensive Benefits)	1915(b)	x	x
TX	STAR	PCCM Provider	1915(b)	x	x
TX	STAR+PLUS	MCO (Comprehensive Benefits)	1915(b)/(c)	x	x
TX	STAR+PLUS	PCCM Provider	1915(b)/(c)	x	
UT	Prepaid Mental Health Program	Mental Health (MH) PIHP	1915(b)	x	x
UT	Primary Care Network (PCN)	Mental Health (MH) PIHP	1115(a)	x	x
VA	MEDALLION/Medallion II	MCO (Comprehensive Benefits)	1915(b)	x	x
VA	MEDALLION/Medallion II	PCCM Provider	1915(b)	x	x
VT	Global Commitment to Health	MCO (Comprehensive Benefits)	1115(a)	x	x
WA	Medicare/Medicaid Integration Partnership (MMIP)	MCO (Comprehensive Benefits)	1932(a)	x	x
WA	The Integrated Mental Health Services	Mental Health (MH) PIHP	1915(b)	x	x
WA	Washington Medicaid Integration Partnership (WMIP)	MCO (Comprehensive Benefits)	1932(a)	x	x
WI	BadgerCare [SCHIP]	MCO (Comprehensive Benefits)	1115(a)	x	x
WI	Children Come First (CCF)	MH/SUD PIHP	1915(a), voluntary	x	x
WI	Family Care	LTC PIHP	1915(b)/(c)		x
WI	Medicaid HMO Program	MCO (Comprehensive Benefits)	1932(a)	x	x
WI	Medicaid SSI Managed Care Program	MCO (Comprehensive Benefits)	1932(a)	x	x
WI	Wisconsin Partnership Program	MCO (Comprehensive Benefits)	1115(a)	x	x
WI	Wraparound Milwaukee	MH/SUD PIHP	1915(a), voluntary	x	x

*Managed Care Entity Type is considered "Other".

Scope of Part D Coverage for Medicaid Programs that Provide a Part D Benefit as of June 30, 2006

State	Program Name	Managed Care Entity Type	Standard Prescription Drug Coverage	Basic Alternative Coverage	Enhanced Alternative Coverage
California	AIDS Healthcare Foundation	MCO (Comprehensive Benefits)	X		
California	Prepaid Health Plan Program	MCO (Comprehensive Benefits)	X		
California	Sacramento Geographic Managed Care (CCS/Dental)	MCO (Comprehensive Benefits)	X		
California	San Diego Geographic Managed Care	MCO (Comprehensive Benefits)	X		
California	Senior Care Action Network	Social HMO	X		
California	Two-Plan Model Program	MCO (Comprehensive Benefits)	X		
Kentucky	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	X		
Minnesota	Minnesota Senior Health Options Program (MSHO)	MCO (Comprehensive Benefits)	X		
New York	Partnership Plan-Medicaid Advantage	MCO (Comprehensive Benefits)	X		
Pennsylvania	Voluntary HMO Contracts	MCO (Comprehensive Benefits)	X		
Puerto Rico	Medicare Platino	MCO (Comprehensive Benefits)	X		
Puerto Rico	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	X		
Puerto Rico	Puerto Rico Health Care Plan	MH/SUD PIHP	X		
Utah	Choice of Health Care Delivery	Medical-only PIHP	X		
Utah	Primary Care Network (PCN)	Medical-only PIHP	X		
Vermont	Global Commitment to Health	MCO (Comprehensive Benefits)	X		
Washington	Medicare/Medicaid Integration Partnership (MMIP)	MCO (Comprehensive Benefits)	X		
Washington	Washington Medicaid Integration Partnership (WMIP)	MCO (Comprehensive Benefits)	X		

State Medicaid Coverage of Part D Excluded Drugs in Medicaid Managed Care Entity Contracts as of June 30, 2006

State	Program Name	Managed Care Entity Type	None -- Managed care entity provides standard prescription drug coverage	Agents when used for anorexia, weight loss, weight gain	Agents when used to promote fertility	Agent when used for cosmetic purposes or hair growth
CA	AIDS Healthcare Foundation	MCO		X	X	X
CA	PACE	PACE		X	X	X
CA	Prepaid Health Plan Program	MCO		X	X	X
CA	Sacramento Geographic Managed Care	MCO		X	X	X
CA	San Diego Geographic Managed Care	MCO		X	X	X
CA	Santa Barbara Health Initiative	MCO	X			
CA	Senior Care Action Network	Social HMO		X	X	X
CA	Two-Plan Model Program	MCO		X	X	X
CO	PACE	PACE				
FL	PACE	PACE				X
KS	PACE	PACE				X
KY	Kentucky Health Care Partnership Program	MCO	X			
MD	PACE	PACE	X			
MA	PACE	PACE		X	X	X
MI	PACE	PACE	X			
MN	Minnesota Disability Health Options (MnDHO)	MCO				
MN	Minnesota Prepaid Medical Assitance-1115(a)	MCO				
MN	Minnesota Senior Care/Minnesota Senior Care Plus	MCO				
MN	Minnesota Senior Health Options Program (MSHO)	MCO				
MO	PACE	PACE	X			
NM	PACE	PACE	X			
NY	PACE	PACE				
NY	Partnership Plan-Medicaid Advantage	MCO	X			
OH	PACE	PACE		X		X
OR	Oregon Health Plan	MCO				
OR	PACE	PACE	X			
PA	PACE	PACE	X			
PA	Voluntary HMO Contracts	MCO	X			
PR	Medicare Platino	MCO				
PR	Puerto Rico Health Care Plan	MCO				
PR	Puerto Rico Health Care Plan	MH/SUD PIHP				
RI	PACE	PACE		X		
TN	PACE	PACE		X	X	X
TN	TennCare	Pharmacy Benefit Mgr*				
TX	PACE	PACE	X			
UT	Choice of Health Care Delivery	Medical-only PIHP	X			
UT	Primary Care Network (PCN)	Medical-only PIHP	X			
VT	Global Commitment to Health	MCO		X		
WA	Medicare/Medicaid Integration Partnership (MMIP)	MCO				
WA	PACE	PACE				X
WA	Washington Medicaid Integration Partnership (WMIP)	MCO				
WI	PACE	PACE	X			
WI	Medicaid SSI Managed Care Program	MCO	X			

*Managed Care Entity Type is "Other".

State Medicaid Coverage of Part D Excluded Drugs in Medicaid Managed Care Entity Contracts as of June 30, 2006

State	Program Name	Managed Care Entity Type	Agents when used for symptomatic relief of cough and colds	Prescription vitamins and mineral products except prenatal vitamins and fluoride preparations	Non-prescription drugs	Barbiturates	Benzodiazepines	Drugs used to promote fertility	Smoking Cession (except dual eligibles as Part D will cover)
CA	AIDS Healthcare Foundation	MCO	X	X	X		X	X	
CA	PACE	PACE	X	X	X		X	X	
CA	Prepaid Health Plan Program	MCO	X	X	X	X	X	X	
CA	Sacramento Geographic Managed Care (CCS/Dental)	MCO	X	X	X	X	X	X	
CA	San Diego Geographic Managed Care	MCO	X	X	X	X	X	X	
CA	Santa Barbara Health Initiative	MCO							
CA	Senior Care Action Network	Social HMO	X	X	X	X		X	
CA	Two-Plan Model Program	MCO	X	X	X	X	X	X	
CO	PACE	PACE	X	X	X	X	X		
FL	PACE	PACE	X		X				
KS	PACE	PACE	X		X				
KY	Kentucky Health Care Partnership Program	MCO							
MD	PACE	PACE							
MA	PACE	PACE	X	X	X	X	X	X	X
MI	PACE	PACE							
MN	Minnesota Disability Health Options (MnDHO)	MCO	X	X	X	X	X		X
MN	Minnesota Prepaid Medical Assitance-1115(a)	MCO	X	X	X	X	X		X
MN	Minnesota Senior Care/Minnesota Senior Care Plus	MCO	X	X	X	X	X		X
MN	Minnesota Senior Health Options Program (MSHO)	MCO	X	X	X	X	X		X
MO	PACE	PACE							
NM	PACE	PACE							
NY	PACE	PACE			X				
NY	Partnership Plan-Medicaid Advantage	MCO							
OH	PACE	PACE	X	X	X	X	X		X
OR	Oregon Health Plan	MCO				X	X		
OR	PACE	PACE							
PA	PACE	PACE							
PA	Voluntary HMO Contracts	MCO							
PR	Medicare Platino	MCO		X		X	X		
PR	Puerto Rico Health Care Plan	MCO		X		X	X		
PR	Puerto Rico Health Care Plan	MH/SUD PIHP		X		X	X		
RI	PACE	PACE	X	X	X	X	X		
TN	PACE	PACE	X	X	X	X	X	X	
TN	TennCare	Pharmacy Benefit Mgr*	X		X				
TX	PACE	PACE							
UT	Choice of Health Care Delivery	Medical-only PIHP							
UT	Primary Care Network (PCN)	Medical-only PIHP							
VT	Global Commitment to Health	MCO		X	X	X	X		
WA	Medicare/Medicaid Integration Partnership (MMIP)	MCO			X		X		
WA	PACE	PACE	X		X				
WA	Washington Medicaid Integration Partnership (WMIP)	MCO			X		X		
WI	PACE	PACE							
WI	Medicaid SSI Managed Care Program	MCO							

*Managed Care Entity Type is "Other".

FACT SHEET

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- Alaska – Non-Emergency Transportation is a new 1915(b) program.

- Alabama – Maternity Care Program was converted from a 1932(a) to a 1915(b) in September 2005.

- California – Sacramento Geographic Managed Care (CSS/Dental), San Diego Geographic Managed Care, and California Two-Plan Model were operating under the 1915(b) program. In 2006, the programs were operating under both, the 1915(b) and 1932(a). Family Mosaic is a new 1915(a), voluntary program.

- Georgia – Georgia Healthy Families is a new 1932(a) program.

- Indiana – Eliminated the PCCM program under Hoosier Healthwise. All the enrollees under the PCCM program were transitioned to the MCO program. Disease Management PCCM was incorporated as a new service under the Medicaid Select PCCM Program.

- Louisiana – Community Care program was converted from a 1915(b) to a 1932(a).

- Minnesota – Minnesota Prepaid Medical Assistance Program was operating under the 1115(a). In 2006, this program was operating under both the 1932(a) and 1115(a). Minnesota Senior Care/Minnesota Senior Care Plus is a new 1915(b)/(c) program.

- Missouri – Transportation PAHP was incorporated as a new service under the MC+ Managed Care 1915(b) program.

- New Jersey – NJ's Care 2000+ changed its name to NJ Familycare.

- New Mexico – New Mexico Salud! program converted from a 1915(b)/(c) to a 1915(b). Mental Health PIHP was incorporated as a new service under New Mexico SALUD! program.

- New York – Partnership Plan – Medicaid Advantage is a new 1915(b) program. New York's Non-Emergency Transportation Program has been terminated.

- Nevada – The Mandatory Non-Emergency Transportation Broker program was converted from a 1915(b) to 1932(a).

- North Dakota – North Dakota Access and Care Program name was changed to North Dakota Medicaid Managed Care Program.

- Ohio – PremierCare Program changed its name to State Plan Amendment for Ohio's Full Risk Managed Care Program and converted from a 1915(b) to a 1932(a) in July 2005. The Enhancement Care Management program was terminated. Atrium Health Plan program is now Compcare.

- Oklahoma – The Non-Emergency Transportation program converted from a 1915(b) to a 1932a.

- Puerto Rico – Medicare Platino is a new 1915(a), voluntary program which serves only dual eligibles. Puerto Rico Health Care Reform Program name was changed to Puerto Rico Health Care Plan.
- Rhode Island – Program of All-inclusive Care for the Elderly (PACE) is a new PACE program.
- South Carolina – Medically Fragile Children is a new 1915(a), voluntary program.
- Tennessee – Dental Benefit Manager and Pharmacy Benefit Manager were incorporated as new services under the 1115 TennCare program
- Vermont – Vermont Health Access program expired in September 05. Global Commitment to Health is the new 1115 program.
- Virginia – Medallion I 1915(b) program (PCCM) was incorporated under the 1915(b) Medallion II program (MCO) in March 2005. Non-Emergency Transportation is a new 1915(b) program.
- Washington – Medicare/Medicaid Integration Partnership (MMIP) is a new 1115 program.
- West Virginia – The 1915(b) Physician Assured Access System program was incorporated under the 1915(b) Mountain Health Trust program.

GLOSSARY

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National Summary of State Medicaid Managed Care Programs Glossary as of June 30, 2006

Section: Program Data--Operating Authority Terms

1915(b)(1)	***Service Arrangement provision***. The State may restrict the provider from or through whom beneficiaries may obtain services.
1915(b)(2)	***Locality as Central Broker provision***. Under this provision, localities may assist beneficiaries in selecting a primary care provider.
1915(b)(3)	***Sharing of Cost Savings provision***. The State may share cost savings, in the form of additional services, with beneficiaries.
1915(b)(4)	***Restriction of Beneficiaries to Specified Providers provision***. Under this provision, States may require beneficiaries to obtain services only from specific providers.
1115(a)	***Research and Demonstration Clause***. The State utilizes specific authority within Section 1115(a) of the Social Security Act to allow the State to provide services through the vehicle of a Research and Demonstration Health Care Reform waiver program.
1932(a)	***State Option to use Managed Care.*** This section of the Act permits States to enroll their Medicaid beneficiaries in managed care entities on a mandatory basis without section 1915(b) or 1115 waiver authority.
1902(a)(1)	***Statewideness***. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. Waiving 1902(a)(1) indicates that this waiver program is not available throughout the State.
1902(a)(10)(B)	***Comparability of Services***. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance. Waiving 1902(a)(10)(B) indicates that the scope of services offered to beneficiaries enrolled in this program are broader than those offered to beneficiaries not enrolled in the program.
1902(a)(23)	***Freedom of Choice***. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in

the State. Under this program, free choice of providers is restricted.

Section: Service Delivery--Managed Care Entity Terms

PCCM	***Primary Care Case Management (PCCM) Provider*** is usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category include PCCMs and those PIHPs which act as PCCMs.
PIHP	**Prepaid Inpatient Health Plan (PIHP)** – A PIHP is a prepaid **inpatient** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are define in 42 CFR 438.2} There are several types of PIHPs that States use to deliver a range of services. For example, a Mental Health (MH) PIHP is a managed care entity that provides only mental health services.
PAHP	**Prepaid Ambulatory Health Plan (PAHP)** – A PAHP is a prepaid **ambulatory** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2} There are several types of PAHPs that States use to deliver a range of services. For example, a Dental PAHP is a managed care entity that provides only dental services.
MCO	***Managed Care Organization*** is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of §1902 (w) to provide comprehensive services.
HIO	***Health Insuring Organization*** is an entity that provides for or

arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Section: Service Delivery--Reimbursement Arrangement Terms

Fee-For-Service	The managed care entity is paid for providing services to enrollees solely through fee-for-service payments, plus in a PCCM, a case management fee.
Risk-based Capitation	The managed care entity is paid for providing services to enrollees primarily through capitation. (There may be other payments under the contract such as incentive arrangements or risk-sharing.)
Non-risk Capitation	The managed care entity is paid for providing services to enrollees through capitation, but payments are settled at the end of the year at amounts that do not exceed the FFS cost for services actually provided, plus an amount for administration.

Section: Quality Activity Terms

Accreditation for Deeming	Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.
Accreditation for Participation	State requirement that plans must be accredited to participate in the Medicaid managed care program.
Consumer Self-Report Data	Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO, PIHP, or PAHP. The survey may be conducted by the State or a contractor to the State.
Encounter Data	Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO, PIHP, PAHP institutional or practitioner provider. The level of detail about each service reported is similar to

	that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".
Enrollee Hotlines	Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO, PIHP, PAHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.
Focused Studies	State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO, PIHP, PAHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO, PIHP, PAHP staff or more than one of these entities may perform such studies at the discretion of the State.
MCO/PIHP/PAHP	These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PIHP/PAHP must have in order to participate in the Medicaid program.
Monitoring of Standards	Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.
Ombudsman	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PIHP/PAHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PIHP/PAHP, and the provider (as appropriate) to resolve individual enrollee problems.
On-Site Reviews	Reviews performed on-site at the MCO/PIHP/PAHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.
Performance Improvement Projects	Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis

	and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PIHP/PAHPs choosing or prescribed by the State.
Performance Measures	Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PIHP/PAHP.
Provider Data	Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.
HEDIS Measures from Encounter Data	*Health Plan Employer Data and Information Set (HEDIS)* measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).
EQRO	Federal law and regulations require States to use an *External Quality Review Organization (EQRO)* to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.
Pay for Performance (P4P)	P4P programs are designed to improve patients' quality of care by recognizing and rewarding high standards of care. This section identifies the States' implementation of a P4P program with any MCOs participating in the State's managed care program.

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